STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676136	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huebner Creek Health & Rehabilitation Center	8306 Huebner Rd San Antonio, TX 78240

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure, in accordance with accepted professional standards and practices, medical records were maintained on each resident that were complete and accurately documented for 1 (Resident #1) of 3 residents reviewed for clinical records. The facility failed to ensure Resident #1's wound care treatments were accurately documented on his Wound Administration Record (WAR) for 3 (06/14/2025 ***Ev, 06/15/2025 Day, and 06/15/2025 ***Ev) of 39 treatments scheduled between the day shift of 06/01/2025 through the day shift of 06/20/2025 reviewed. This failure could place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records. Findings included: Record review of Resident #1's admission Record, dated 06/24/2025, reflected a [AGE] year-old male. He was admitted to the facility on [DATE]. Record review of Resident #1's Diagnosis Report, dated 06/24/2025, reflected a primary diagnosis of acute respiratory failure with hypoxia (a sudden condition when the lungs cannot deliver enough oxygen to the blood), and secondary diagnoses of quadriplegia (paralysis of all four limbs), and atelectasis (a condition where the airways or air sacs in the lungs collapse or do not fully expand). Record review of Resident #1's Modified admission MDS, dated [DATE] and signed as completed on 05/23/2025, reflected Resident #1 had a BIMS score of 15, which indicated he was cognitively intact. He had impairment on both sides of his upper and lower extremities and was dependent for all his self-care and mobility needs. He was documented as at risk for developing pressure ulcers/injuries, did not have a pressure ulcer/injury, and had moisture associated skin damage (MASD). Record review of Resident #1's Order Recap Report for Order Date: 05/19/2025- 06/30/2025, dated 06/24/2025, reflected an order Cleanse MASD to the sacral area [area at the base or last bone of the spine] w/wound [sic] cleanser or NS [Normal Saline], pat dry. Apply Triad to the area and leave open to air. every [sic] 8 hours as needed for Wound management AND every day and evening shift for wound management, dated as ordered and started 05/20/2025. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's 06/01/2025- 06/30/2025 Wound Administration Record, dated 06/24/2025, revealed the order Cleanse MASD to the sacral area w/wound [sic] cleanser or NS, pat dry. Apply Triad to the area and leave open to air. every day and evening shift for wound management. The WAR indicated the treatment was to be provided twice a day at the hours of Day and ***Ev. The WAR revealed blanks for 06/14/2025 ***Ev, 06/15/2025 Day, and 06/15/2025 ***Ev. Record review of Resident #1's 06/01/2025- 06/30/2025 Treatment Administration Record, dated 06/24/2025, revealed the order May have pressure relieving mattress every shift. The TAR indicated the treatment was to be provided twice a day at the hours of Day, ***Ev, and ***Ni. The TAR revealed LPN D checked off the order as administered on 06/14/2025 ***Ev, LPN C on 06/15/2025 Day, and RN E on 06/15/2025 ***Ev. Observation and interview with Resident #1 on 06/26/2025 at 08:40 a.m., revealed Resident #1 admitted , on 06/20/2025, to a local hospital for pneumonia (a lung infection). Due to his positioning in bed, Resident #1's sacral area was not visible. He revealed he did not know if the wound treatments were provided on the evening of 06/14/2025 (Saturday) or the day and evening of 06/15/2025 (Sunday). He stated due to his long-term nursing facility experience as a resident, he would have only considered a wound care treatment as having been provided if it was done by the wound care nurse and on a Monday, Wednesday, or Friday. He stated he did not recall if a nurse applied any type of cream or ointment to his sacral area on those dates or times. During an interview with LPN B on 06/26/2025 at 10:59 a.m., LPN B revealed she was the facility wound care nurse and she was scheduled to work Monday through Friday. She revealed she did not regularly work on the weekends. She revealed she did not know what a blank in the WAR indicated. She revealed the direct care nurses were expected to provide Resident #1's wound care when she was not in the facility, and they were able to click on the administration record to indicate that the treatment was provided. She revealed she did not believe Resident #1's wound would have been impacted if he missed three treatments because he was also receiving barrier cream applied by the CNAs after each incontinent care episode. LPN B revealed Resident #1 was admitted to the facility with the MASD and his skin did not have a significant change during his admission. During an interview with LPN C on 06/26/2025 at 12:21 p.m., LPN C revealed she worked PRN and was recently scheduled primarily Saturdays and Sundays. LPN C revealed she did recall providing Resident #1 care on 06/15/2025 and administering cream on his rash. She stated she must have just not marked in the administration record that the treatment was done. She stated the impact of not documenting the completion of the treatment would be that it would look on the record as if the treatment was not administered. She stated a treatment marked as not done might result in another nurse believing they needed to also complete the treatment. RN E was attempted to be interviewed via telephone on 06/26/2025 at 04:05 p.m. and 05:07 p.m. A voice mail was left following the first attempt with a request for a return call and contact information. A return phone call was not received. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LPN D on 06/26/2025 at 04:09 p.m., LPN D revealed she worked double weekends, day and evening shift. She revealed 06/14/2025 was her first day working as a direct care nurse on the floor at the facility. She revealed she did recall providing Resident #1's wound care on 06/14/2025. She revealed the facility's EMR was organized differently than she was used to, and she might have not noticed the wound care order was documented under Wound Administration Record tab. She revealed she probably didn't mark the order as completed. She stated a documentation missed would result in the appearance of a missed treatment. During an interview with the DON on 06/26/2025 at 04:42 p.m., the DON revealed orders scheduled as Day were to be completed between 06:00 a.m. to 02:00 p.m., and those scheduled as ***Ev were to be completed between 02:00 p.m. to 10:00 p.m. She revealed a blank in an administration record would typically indicate a missed administration of a treatment or medication. She revealed if a staff member missed documenting the administration of a treatment or medication, it would impact the monitoring of that order's administration. During an interview with the ADMIN on 06/26/2025 at 05:18 p.m., the ADMIN revealed missed documentation of a treatment or medication would not impact the resident, unless the missed documentation resulted in someone providing the treatment again due to believing the treatment was not done. She revealed the potential double administration of a medication or treatment could be harmful. A facility policy covering treatment documentation was requested. The ADMIN provided the policy, PCU018- Medication Administration and General Guidelines, dated v3-2025. Record review of a facility policy titled PCU018- Medication Administration and General Guidelines, dated v3-2025, reflected 7. Topical medications used in treatments are listed on the treatment administration record (TAR) .9 . only the licensed or legally authorized personnel who prepare a medication may administer it. This person then records the administration on the residents MAR at the time the medication is given .11. The resident's MAR is initialed by the person administering a medication .Or if utilizing an Electronic Medical Record, the initials of the nurse are electronically stamped into the record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections for 1 (CNA F) of 5 staff observed for infection control. CNA F failed to perform hand hygiene while serving and assisting residents with their meal on 06/26/2025. These deficient practices placed residents at risk for cross contamination and spread of infection. Findings included: During an observation in the facility 700-hall and facility dining room on 06/26/2025 at 12:06 p.m., CNA F was observed to have left a resident room after delivering a meal tray. She took off and adjusted her eyeglasses, put her glasses back on, grabbed another resident's meal tray, and walked down the hall toward the facility dining room while holding the resident lunch tray. In-route she adjusted her eyeglasses a second time with one hand, placed the meal tray on the table in-front of a resident, sat down, picked up the resident's meal utensils, and while holding the resident's utensils proceeded to cut up the resident's food. CNA F was not observed to sanitize her hands following touching her face and personal glasses, and prior to touching the resident's utensils. Record review of facility in-service training, topic noted as Meal Tray Pass, dated 06/17/2025, revealed 23 nursing staff signatures for attendants. CNA F was not noted as an attendant. During an interview with CNA F on 06/26/2025 at 01:15 p.m., CNA F revealed she was aware she was to sanitize or wash her hands between serving and assisting each resident with their meal. She stated she did not know what the procedure was following touching her glasses. She revealed hand sanitation during meal service was important to ensure the staff were not transferring anything dirty to residents. During an interview with the DON on 06/26/2025 at 04:42 p.m., the DON revealed her expectation for staff was for staff to use hand sanitizer prior to starting tray service and in-between every resident's tray. She revealed she had provided staff training on her expectation, and it was reviewed during the 06/17/2025 staff in-service. During an interview with the ADMIN on 06/26/2025 at 05:18 p.m., the ADMIN revealed her expectation for staff was for staff to use hand sanitizer between every resident tray delivery. She revealed the failure to sanitize might result in possible contamination of the resident's meal tray. She revealed her expectation for staff was the same for if the staff member touches their face or glasses. She revealed in past staff trainings, she had mentioned her expectations for if the staff touch their hair and face. Record review of a facility policy titled Hand Hygiene, undated, reflected Hand hygiene continues to be the primary means of preventing the transmission of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy titled Nursing Responsibilities at Meal Service, dated 2012, did not reflect information regarding hand hygiene during meal service.