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	11/26/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 of 6 (Resident # 1) reviewed for call light. The facility failed to ensure Resident # 1's call light was within reach. This failure could place residents at risk of achieving independent functioning, dignity, and well-being. Findings include: Record review of Resident # 1's face sheet dated 10/22/25 revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident # 1had a diagnosis that included: Quadriplegia (a condition characterized by paralysis or severe weakness in all four limbs), Muscle wasting and atrophy (refers to the loss of body mass and strength), and Acute respiratory failure (a life-threatening condition where the lungs cannot exchange oxygen and carbon dioxide). Record review of Resident # 1's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 15, which indicated no cognitive impairment. Review of Resident # 1's Quarterly MDS assessment, dated 9/3/25, Resident #1 required full assistance with 2 persons. Record review of Resident #1's care plan, revised 6/4/2025, revealed a care plan with interventions encourage the resident to use bell for assistance. Observation and interview on 10/23/25 in Resident # 1's room at 2:35 PM revealed that the call light was found inside the nightstand. Resident #1 stated, Staff do this to him all the time, which make him upset and forced him to call the facility's phone number for help. Interview with LVN B on 10/23/2025 at 2:38 PM: He confirmed that the call light for Resident # 1 was in the nightstand. He did not know why it was not accessible to Resident #1; he quickly placed the call light close to Resident # 1. LVN B stated that the lack of accessibility of a call light for any resident was not good nursing practice. He indicated that Resident #1 could not call for help if his call light was inaccessible. Interview on 10/24/25 at 8:40 AM, CNA A stated that he was the assigned nursing assistant for Resident #1 on 10.23.2025, day shift. She mentioned she must have forgotten to place the call light next to Resident #1, and she left it on the nightstand when she returned Resident #1 to bed after a shower the previous day, near the end of her shift. She also stated that if any resident lacked access to the call light, it could lead to a fall if they needed assistance. Interview with the ADON on October 23, 2025, at 1:00 PM; revealed she was conducting in-service training for all nursing staff on call light procedures to ensure 100% compliance. She said she was responsible for overseeing charge nurses and nursing assistants to ensure all residents had access to a call light. Interview with the DON on October 23, 2025, at 3:00 PM, revealed she emphasized the importance of ensuring the call light was accessible to all residents. She stated that any resident without access to a call light could face adverse outcomes when they needed assistance. The DON mentioned that charge nurses monitor this process during their daily shift rounds, and her ADON oversaw it. Although she stated that there was no formal policy addressing this deficiency, she assured the surveyor that staff receive training on call light placement during every staff meeting.

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure each resident had the right to observe resident's religious beliefs in the facility that were significant to the resident for one (Resident #5) of twelve residents reviewed for self-determination. The facility failed to promote Resident #5's self-determination by not honoring his choice to practice his religion. This failure could place residents at risk for poor self-esteem and decreased self-worth due to their needs and preferences not being met. Findings included:Record review of Resident #5's admission record, dated 10/23/25, reflected an [AGE] year-old male initially admitted [DATE] and re-admitted [DATE] with diagnoses to include dementia (loss of cognitive functioning that interferes with daily life and activities), need for assistance with personal care, and depression. Record review of Resident #5's quarterly MDS assessment, dated 09/09/25, reflected Resident #5 had a BIMS of 9 out of 15, indicating moderate cognitive impairment. Record review of Resident #5's care plan, undated, reflected no mention of his religion in his care plan to include activities, except a focus .Due to religious beliefs, the resident is on a selective menu for breakfast/dinner. Interview on 10/22/25 at 01:52 PM, Resident #5 revealed he was Muslim, and he let the facility know. He revealed he was not given any alternatives to practice his religion, and the staff were aware of this. He further revealed it made him feel left out because other residents were able to attend Bible study, and he could not practice his religion. He revealed he would like to watch a religious program on his TV, but his TV had not been working. Resident #5 could not recall how long his TV had not been working and the facility was aware of this issue. Interview on 10/23/25 at 02:34 PM, LVN H revealed she was not aware of Resident #5's preferences regarding religion. She revealed it was important to respect people's religion and beliefs. Interview on 10/24/25 at 08:37 AM, Resident #5 revealed he wanted staff to know he was Muslim because if they did not know how they would be able to care for him accordingly. He revealed he did not have food before his fasting during [NAME] but did not want to ask because the facility gave meals 3 times a day at certain times and did not think they could accommodate him. Resident #5 revealed he told everyone about his religion to include staff because he was proud to be Muslim. He revealed he felt upset because this was not his home because he could not practice his religion Interview on 10/24/25 at 09:07 AM, the Activities Director revealed she thought it was important for Resident #5 to practice his religion. She revealed she had tried various activities to support his religion and tried getting his family involved, but her attempts did not meet Resident #5's expectations. Interview on 10/24/25 at 09:55 AM, the DON revealed it was important to offer activities to residents for their mental well-being. She revealed it was important for staff to know about Resident #5's religion so they could support him in his religion. Interview on 10/24/25 at 11:25 AM, the ADM revealed they had been trying to fix Resident #5's TV. (Evidence to support this was requested and has not been provided) Record review of facility's policy Resident Rights, revised 11/28/16, reflected A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that include measurable objectives and time frames to meet residents' mental, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and to ensure that the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including the right to refuse treatment for 2 of 12 residents (Residents #2 and #5) reviewed for care plans, in that. 1. The facility failed to update Resident #5's care plan to reflect his religion. 2. The facility failed to update Resident #2's care plan to reflect his diagnosis of PTSD. This failure could place residents at risk of not receiving appropriate care. The findings included: Record review of Resident #5's admission record, dated 10/23/25, reflected an [AGE] year-old male initially admitted [DATE] and re-admitted [DATE] with diagnoses to include dementia (loss of cognitive functioning that interferes with daily life and activities), need for assistance with personal care, and depression. Record review of Resident #5's quarterly MDS assessment, dated 09/09/25, reflected Resident #5 had a BIMS of 9 out of 15, indicating moderate cognitive impairment. Record review of Resident #5's care plan, undated, reflected no mention of his religion in his care plan to include activities, except a focus .Due to religious beliefs, the resident is on a selective menu for breakfast/dinner. Interview on 10/22/25 at 01:52 PM, Resident #5 revealed he was Muslim, and he let the facility know. He revealed he was not given any alternatives to practice his religion, and he revealed the staff were aware of this. He further revealed it made him feel left out because other residents were able to attend Bible study and he could not practice his religion. 2. Record review of Resident #2's admission record, dated 10/21/25, reflected a [AGE] year-old male admitted [DATE] with diagnoses to include Post-Traumatic Stress Disorder and Traumatic Brain Injury. Record review of Resident #2's quarterly MDS assessment, dated 07/06/25, reflected Resident #2 had a BIMS of 15 out of 15, indicating intact cognition. Record review of Resident #2's care plan, undated, reflected no mention of his diagnosis of PTSD in his care plan. Interview on 10/22/25 at 02:30 PM, Resident #2 revealed he had PTSD due to TBI and doing puzzles in the activities room at night allowed him to get lost in the puzzle and he forgot about his problems and past trauma. Interview on 10/23/25 at 01:16 PM, CNA G revealed they had not known Resident #5's religion and did not know what to do. They further revealed they were unsure if Resident #2 had PTSD. They revealed they would know this information by asking other staff members or look at residents' care plans to learn about individualized resident care. Interview on 10/23/25 at 02:34 PM, LVN H revealed Resident #2 had PTSD and knew Resident #2 did not like loud noises, so they helped him avoid social areas when it was loud. She revealed this should be care planned for resident care. She revealed she was not aware of Resident #5's preferences regarding religion. She revealed she would hope religion was care planned because it was important to respect people's religion and beliefs. Interview on 10/23/25 at 03:10PM, LVN C revealed Resident #5's meals were adjusted according to his religion, but she was not aware of his specific religion. She revealed she believed religion should be care planned if they needed to know something specific about Resident #5's care. She revealed Resident #2 had PTSD where noise bothered him and she knew how to calm him down. She revealed she was unsure if it was care planned but she'd have to look at care plan. Interview on 10/23/25 at 03:37 PM, CNA D revealed he was unsure what Resident #5's religion was. He was unsure if this was care planned. He revealed he felt that if the residents wanted anyone to know their religion, then the resident would let the facility know. He revealed maybe religion was not care planned because the resident did not want anyone to know. He revealed he was not sure if Resident #2 had PTSD, but he revealed if he saw Resident #2 triggered, he would let the nurse know if he was not able to calm Resident #2 down. Interview on 10/24/25 at 08:37 AM, Resident #5 revealed he wanted staff to know he was [Religion] because if they did not know how they would be able to care for me accordingly. He revealed he did not have food before his fasting during [Religious event] but did not want to ask because the facility gave meals 3 times a day at certain times and did not think they could accommodate him. Resident #5 revealed he told everyone about his religion to include staff because he was proud to be [Religion]. He revealed he felt upset because this is not his home because he can't practice his religion Interview on 10/24/25 at 09:07 AM, the Activities Director revealed she thought it was important for religion to be on the care plan for Resident #5 so that the staff can care for him appropriately. She revealed she believed the Social Worker was in charge of care planning a resident's

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide activities based on the comprehensive assessment and care plan, designed to meet the interests of and support the physical, mental and psychosocial well-being of 3 (Resident #2, 3, 4) out of 12 who were reviewed for activities. The facility failed to consistently provide individualized activities and did not meet the needs of the Resident #2, #3, and #4, especially nights and weekends. These failures placed the residents at risk of becoming apathetic (marked indifference to the environment), isolated from others, having a depressed mood, boredom, loneliness, and a decreased quality of life. Findings included: Record review of Resident #4's admission record, dated 10/21/25, reflected a [AGE] year-old female initially admitted [DATE] and re-admitted [DATE] with diagnoses to include depression. Record review of Resident #4's quarterly MDS assessment, dated 09/01/25, reflected Resident #3 had a BIMS of 15 out of 15, indicating intact cognition. Record review of Resident #4's care plan, undated, reflected focus The resident needs out of room social, spiritual, and stimulus activities and mental stimulation, initiated 01/15/25, with intervention, The activity [director] will praise the resident for attending activities of her choice, initiated 01/15/25. Record review of Resident #3's admission record, dated 10/21/25, reflected a [AGE] year-old female initially admitted [DATE] and re-admitted [DATE] with diagnoses to include depression. Record review of Resident #3's quarterly MDS assessment, dated 09/01/25, reflected Resident #3 had a BIMS of 15 out of 15, indicating intact cognition. Record review of Resident #3's care plan, undated, reflected focus The resident needs out of room social, spiritual, and stimulus activities and mental stimulation, initiated 01/15/25, with intervention, The activity [director] will praise the resident for attending activities of her choice, initiated 01/15/25. Record review of Resident #2's admission record, dated 10/21/25, reflected a [AGE] year-old male admitted [DATE] with diagnoses to include Post-Traumatic Stress Disorder and Traumatic Brain Injury. Record review of Resident #2's quarterly MDS assessment, dated 07/06/25, reflected Resident #2 had a BIMS of 15 out of 15, indicating intact cognition. Record review of Resident #2's care plan, undated, reflected focus [Resident #2] needs out of room social, spiritual, and stimulus activities and mental stimulation, initiated 05/13/23, with intervention, The activity [director] will praise the resident for attending activities of her choice, revised 04/28/24. Observation on 10/21/25 at 10:33 AM reflected a sign on both doors of the activities room that stated: Activity Room Hours: Mon-Fri 9am-11am and 1:30pm-4:30pm. Interview on 10/21/25 at 12:33 PM, the ombudsman revealed the activities room was a sanctuary for residents. She revealed the residents were upset. She recalled Resident #2 would visit the activities room at night so he could continue working on his puzzle when no resident was in the activities room. She revealed this impacted Resident #2's quality of life. She further revealed, since the activities room was only open 5 hours a day, he could not continue his puzzle so he would instead lay in his room and stare at the ceiling. Interview on 10/21/25 at 03:16 PM, Resident #4 revealed he liked to do puzzles and did not understand why he could not do puzzles in the activities room. He revealed doing puzzles in the activities room stimulated his mind. He revealed they took something away from him that they enjoyed having. He revealed we are not in jail and should have access to the room for more than 5 hours a day. He revealed his puzzle was too complex to take out of the activities room and needed to be worked on inside the activities room. He also revealed he liked to do puzzles at night when the room was empty. Interview and observation on 10/21/25 at 03:27 PM, Resident #3 was laying in her bed. She revealed she enjoyed doing activities, but the activities room was closed because there was a singer doing activities in the dining room. She said it was depressing because she would like to be in the activities room doing her puzzle. She revealed she enjoyed doing puzzles, drawing, and painting. She revealed the activities room was closed after 4:30PM and on the weekends. She revealed she liked doing her puzzles after 4:30PM because it was more relaxing for her. She revealed at night there was nothing to do so she mainly wandered in the hallways, feeling lost. She said it was comforting to be in the activities room at night. She revealed she did not like watching TV. She revealed she did more complex puzzles so it was hard to transport her puzzle so she would need to be in the activities room. Interview on 10/22/25 at 02:30 PM, Resident #2 revealed he enjoyed doing puzzles in the activities room. He revealed he had PTSD due to TBI and doing puzzles in the activities room at night allowed him to get lost in the puzzle and he forgot about his problems and past trauma. He revealed when he wanted to continue his puzzle he could not. Interview on 10/23/25 at 02:21 PM, LVN E revealed residents did complain about not having access to activities room but had no specific names of residents. She revealed on the