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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2026

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 observation, interview, and record review, the facility failed to ensure the resident 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 3 residents (Resident #1), reviewed for a call light system. The facility failed to ensure Resident #1 could reach or trigger the call light installed near her bed when she fell on 3/11/26. This failure could place residents at risk of not receiving timely care and nursing interventions; and could result in falls, injuries, a diminished quality of life, and incontinent episodes.The findings include: Record review of Resident #1s face sheet, dated 3/13/26, reflected an 80 -year-old female who was readmitted to the facility on [DATE]. Resident #1 had diagnoses which included sepsis (toxic response to an infection), unspecified organism (at admissions), diabetes (high blood sugar), dementia (decline in mental ability) , hypertension (blood force against an artery is high), and cognitive deficits. The RP was listed as: a Guardian. Record review of Resident #1's significant change MDS, dated [DATE], reflected a BIMS score of 02, indicative of severe impairment in cognition. The resident was incontinent of bowel and had a Foley catheter. Resident #1 was dependent on transfer and mobility. The resident was impaired on upper and lower range of motion. Record review of Resident #1's fall assessment, dated 3/11/26 at 9:30 PM, by LVN A, reflected: history of falls; disoriented, neurological checks done and x-ray results were negative. The fall assessment also reflected that the resident had an unwitnessed fall on 3/11/26 at 9:30 PM, in her room; resident fell to the left side of the bed near the wall; sustained some scratches to the right side of the face. Record review of Resident #1s fall risk score, dated 3/11/26, reflected a score 11 (High). Record review of Resident #1 's x-ray of skull, cervical spine, and right humerus (long bone in the upper arm), dated 3/12/26, reflected no fractures. Record review of Resident #1's, undated, care plan reflected a goal of fall prevention with interventions that included: low bed, call light in reach, clutter free room, call hospice, monitor for risk of falls, and appropriate footwear. After resident experienced a fall on 3/11/26 new interventions included: scoop mattress, floor mats both side of bed, and wedges/bolsters to the bed. Record review of Resident #1's court order, dated 12/19/2025, reflected a temporary Guardian who was assigned to the resident. Observation and interview on 3/13/26 at 4:01 PM, revealed Resident #1 was in bed with a doll present. The door was closed. Floor mats were on both sides of the bed, scooped pressure release mattress with bolsters on both sides present. Observation further revealed small abrasion to right side of face. The call light was a pressure call bulb light; but the resident could not activate due to upper body impairment. The resident spoke in a faint voice. The resident was alert and oriented to herself. The call light was in reach; tied to the left side of the resident's night gown near the left arm. The resident's arms were crossed away from the call light. The resident stated she fell to her right side but did not know the details. Resident #1 said, I fell Tuesday [actual fall was Wednesday] .no pain and do not know why. Resident stated she would ask for help to prevent future falls, but she could not reach or push the call light.Observation on 3/15/26 at 9:30 AM of Resident #1's room revealed the door was open. Resident #1's room was located 3 rooms away from the nurse station which would make it difficult for staff to hear the (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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During an observation and interview on 3/13/26 at 4:45 PM with the Rehab Director, revealed Resident #1 was unable to locate the bulb call light and when the bulb call light was placed on the resident's right hand, by the Rehab Director, the resident was unable to trigger the call light. The resident only smiled when told to find the call light. When instructed by the Rehab Director to trigger the call light the resident was unable, on command, to initiate and follow through on the call light. The Rehab Director stated the facility needed to explore other options such as an adaptive call light because the resident had declined cognitively. The Rehab Director had no explanation for the facility for not exploring another adaptive call light. The Rehab Director stated the resident could experience a fall in the future because the resident could wiggle in her bed. The Rehab Director stated for the resident's safety the facility could explore another adoptive device or re-train the resident on the use of pressure release call lights. During an interview on 3/15/26 at 9:01 AM, the ADON stated the timeline of Resident #1's fall on 3/11/26 was:Nurse Note dated 3/11/26 at 9:20 PM authored by LVN A stated resident was given a Tylenol-codeine pain pill; nothing mentioned about the call light.Nurse Note dated 3/11/26 at 9:30 PM authored by LVN A revealed: the nurse entered the room to administer Resident #1's night medications and found resident on floor next to the bed and wall (left side of bed and left side of location of catheter). The bed was in a low position and call light in reach but call light was off. Head to toe assessment was done; no injuries noted. Vitals within normal limits. Resident was assisted by Hoyer back to her bed. Medications were administered. The resident was unable to provide clear explanation for the fall. MD, hospice, and guardian were notified. Neurological checks were started.3/12/26 at 8:12 AM order by hospice for multiple x-rays (cervical spine, right arm and skull). [ADON attempt to show the fall was without major injury]3/12/27 at 9:40 AM x-rays were all negative. Neurological checks continued.The ADON stated the preventative measure prior to the fall included low bed, wedges on bed and every 2-hour rounding for repositioning. After the fall, the ADON stated new preventative measures included: scoop mattress and floor mats on both sides of bed. The ADON stated he was not aware the resident could not trigger the call light. During an interview on 3/15/26 at 9:53 AM, LVN A stated the same information found in her progress note, dated 3/11/26. LVN A stated Resident #1 could not trigger her call light and needed to move her hand to trigger. LVN A stated on the date and time of the fall the resident did not trigger the call light. LVN A stated the roommate did not have the capacity to call for help for the resident and it was coincidental she found the resident when making rounds to administer the night medications. LVN A stated at the time of the fall there were floor mats and the mattress had wedges and was scooped. LVN A stated the resident was provided no explanation for the fall. LVN A stated the resident was able to wiggle out of the bed at the time of fall on 3/11/26. LVN A stated the new intervention included frequent rounds. LVN A stated Resident #1 could benefit for safety reasons with a roommate who was alert and oriented. LVN A added Resident #1 could be moved to a room closer to the nurse station so nurses could see the resident more frequently. During an interview on 3/15/26 at 10:16 AM, LVN B stated she was aware the resident fell on 3/11/26 at night. LVN B stated preventative measures included: 1-2 hours rounding, floor mats in place, and assessments. LVN B stated the resident could still wiggle in her bed which was intermittent. LVN B stated the resident was able to trigger the call light and there was no need for further accommodations. During an interview on 3/15/26 at 10:29 AM, CNA C stated she had been working with Resident #1 for about one year. CNA C stated she heard about the resident's fall on 3/11/26; fall out of bed. CNA C stated (continued on next page)

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