

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  03/27/2026
NAME OF PROVIDER OR SUPPLIER  Huebner Creek Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate foot care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to ensure they provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) for 3 of 3 residents (Resident #1, Resident #2, and Resident #3) who were reviewed podiatry care. The facility failed to ensure Resident #1, Resident #2, and Resident #3 received podiatry care to maintain proper toenail length during the 3/4/2026 quarterly scheduled visit. The previous visit occurred on 10/28/2025. This failure could place residents at risk of experiencing pain when wearing footwear, difficulty walking, or poor hygiene. The findings were: Review of Resident #1's face sheet, dated 3/25/26, revealed she was an 82 year female who admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including unspecified dementia (decline in cognitive function), type 2 diabetes mellitus (insulin resistance and high blood sugar levels), and need for assistance with personal care. Review of Resident #1's quarterly MDS, dated [DATE], revealed a BIMS score was 15 of 15 reflective of no cognitive impairment and was dependent on staff for putting on/taking off footwear. Review of Resident #1's undated care plan revealed the resident has Diabetes Mellitus with the intervention, refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails. Review of a local podiatry group schedule, dated 3/4/26, revealed they provided podiatry services to multiple residents in the facility. Further review revealed Resident #1 was on the list but was not provided with foot care. The last date of service for Resident #2 was 10/28/2025. Review of Resident #2's face sheet, dated 3/25/26, revealed he was a [AGE] year old male who admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including spinal stenosis, lumbar region with neurogenic claudication (symptoms of back pain, numbness, and weakness), type 2 diabetes mellitus (insulin resistance and high blood sugar levels), and need for assistance with personal care. Review of Resident #2's quarterly MDS, dated [DATE], revealed a BIMS score was 15 of 15 reflective of no cognitive impairment and required substantial to maximum assistance with putting on/taking off footwear. Review of Resident #2's undated care plan revealed the resident has Diabetes Mellitus with the intervention, refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails. Review of a local podiatry group schedule, dated 3/4/26, revealed they provided podiatry services to multiple residents in the facility. Further review revealed Resident #2 was on the list but was not provided with foot care. The last date of service for Resident #2 was 10/28/2025. Review of Resident #3's face sheet, dated 3/25/26, revealed she was a [AGE] years old and admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including unspecified dementia (decline in cognitive function), type 2 diabetes mellitus (insulin resistance and high blood sugar levels), and need for assistance with personal care. Review of Resident #3's quarterly MDS, dated [DATE], revealed a BIMS score of 7 of 15 reflective of moderate cognitive impairment and used a walker to ambulate. Review of Resident #3's undated care plan revealed the resident has Diabetes Mellitus with the intervention, refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails. Review of a local podiatry group schedule, dated 3/4/26, revealed they provided podiatry services to multiple residents in the facility. Further review revealed Resident #3 was on the list but (continued on next page)</p>

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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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>was not provided with foot care. The last date of service for Resident #2 was 10/28/2025. Observation and interview on 3/26/26 at 3:00 PM with Resident #1 revealed he needed help with cutting my toenails. I can't do it. I asked the SW what happened because they used to come every 3 months but haven't had it done lately. Resident #1 stated that 5 months ago was the last time their nails were cut. Resident #1 stated, The nurses don't cut my nails because I have diabetes. The podiatrist has to do it. The resident allowed the investigator to see the length of her toenails which were observed to be up to 1/4 inch beyond the flesh of the toes with some nails curving toward the skin. Interview on 3/26/26 at 10:45 AM Resident #2 stated, We have a podiatrist that cuts toenails. Haven't seen her in quite a while. She's good at what she does. Observation and interview on 3/26/26 at 11:25 AM Resident #3 said she asked them (staff) about getting their toenails cut and they (staff) said as soon as the man comes. Resident #3 stated that their toenails were cut last year. Resident #3 stated, It hurts to wear shoes and it's embarrassing. Resident #3's toenails were observed to be 1/2 to 1 inch beyond the flesh of the toe. Interview with a family member revealed the hospital had noticed the resident needed their nails cut and the social worker had stated that Resident #3 was on the list during the last podiatry visit, but they left before they saw Resident #3. Resident #3 said that she would like to get their toenails cut as soon as possible. Interview on 3/26/26 at 11:44 AM with the ADON revealed Resident #3 was up at the front with the SW early this week, Monday or Tuesday, and the SW stated the podiatrist would come in a month or an outside facility visit could be arranged. The ADON stated that Resident #3 said that she would wait. The ADON stated that Resident #3's toenails were in need of attention but we have to respect the residents wishes if they want to wait. She stated that long toenails can be a fall hazard and could cause pain. Interview on 3/27/26 at 3:55 PM with the DON stated the Social Worker stated that there were some residents that did not receive foot care and that this puts them at risk for injury or infections. They could have a hang nail. They can't wear shoes or a nail could break. Interview on 3/26/26 at 4:52 PM the SW stated, the current podiatry company came in on March 4, 2026, but stated that the list was too long and they were not able to see everyone. The SW stated she had to call them (podiatry company) to provide a list of who they saw. The contracted podiatry company stated they could not come again any earlier than April 20, 2026. The facility's parent company uses a contracted podiatry company for all facilities. I spoke to Resident #3 yesterday and I asked her if she wanted me to make an appointment outside the facility. She stated no, she would wait for the company to return. She knew that the next visit would be on the 20th. She was OK with waiting. She was last seen on 10/28/2026. Nurses and CNAs can cut fingernails. Nurses attend to residents with diabetes. Only the podiatrist cares for toenails. The SW stated, Resident #1, Resident #2, and Resident #3 had insurance which allowed 4-6 podiatry visits per year. Review of a facility policy, Nail Care, undated, revealed Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity of tissues, to prevent infection, and injury from scratching by fingernails or pressure of shoes on toenails. It includes cleansing, trimming, smoothing, and cuticle are and is usually done during the bath. Nails can become thinner and more brittle in the elderly and thicker if peripheral circulation is impaired. Nails are also important in assessment, as changes occur with certain medical conditions, such as clubbing with chronic obstructive pulmonary disease or cardiac disease. Color changes with circulatory or lymphatic impairment and certain drug therapy is common. Ingrown toenails are also common in the elderly. Fungal infections of the toenails, dry, brittle ridges and thickening of the nails all occur in the elderly with some frequency. NAIL CARE, ESPECIALLY TRIMMING, IS PERFORMED BY A PODIATRIST IN THOSE WITH DIABETES AND PERIPHERAL VASCULAR DISEASE. Goals Nail care will be performed regularly and safely. The resident will free from abnormal nail conditions The resident will be free from infection.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review 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 2 of 2 residents (Residents #1 and #2) reviewed for medical records. 1. The facility failed to ensure Resident #1's ADL-Bathing record recorded a bath or refusal for 2/28/2026, 3/5/2026, 3/7/2026, 3/10/2026, 3/12/2026, 3/14/2026, 3/17/2026, and 3/24/2026 as noted on the electronic medical record. 2. The facility failed to ensure Resident #2's ADL-Bathing record recorded a bath or refusal for 2/28/2026, 3/5/2026, 3/7/2026, 3/10/2026, 3/12/2026, 3/14/2026, 3/17/2026, and 3/24/2026 as noted on the electronic medical record. These failures could place residents at risk of not receiving necessary care and services to ensure a resident's abilities in ADLs did not deteriorate, promoted proper hygiene, and a dignified existence. Findings include: Review of Resident #1's face sheet, dated 3/25/26, revealed she was an 82 female who admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including unspecified dementia (decline in cognitive function), type 2 diabetes mellitus (insulin resistance and high blood sugar levels), and need for assistance with personal care. Review of Resident #1's quarterly MDS, dated [DATE], revealed a BIMS score was 15 of 15 reflective of no cognitive impairment and was dependent on staff for shower/bathe self. Record review of Resident #1's 30-day Task record for ADL-Bathing reflected a preference of bathing on Tuesdays, Thursdays, and Saturdays. Based on an admission date of 1/1/2026, Resident #1 did not have a bath entry or refusal recorded on the electronic medical record for 2/28/2026, 3/5/2026, 3/7/2026, 3/10/2026, 3/12/2026, 3/14/2026, 3/17/2026, and 3/24/2026. During an observation and interview on 3/26/2026 at 3:00 PM, Resident #1 was sitting alone in the dining hall. Their clothes were clean with a groomed appearance. She stated, she was able to take showers on her scheduled days but sometimes they ask me at 9 AM to 10 AM and it's too early so I may refuse the shower. She revealed it was better after dinner. Review of Resident #2's face sheet, dated 3/25/26, revealed he was a [AGE] years old male who admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including spinal stenosis, lumbar region with neurogenic claudication (symptoms of back pain, numbness, and weakness), type 2 diabetes mellitus (insulin resistance and high blood sugar levels), and need for assistance with personal care. Review of Resident #2's quarterly MDS, dated [DATE], revealed a BIMS score was 15 of 15 reflective of no cognitive impairment and required substantial to maximum assistance from staff for shower/bathe self. Record review of Resident #2's 30-day Task record for ADL-Bathing reflected a preference of bathing on Tuesdays, Thursdays, and Saturdays. Based on a readmission date of 8/9/2025, Resident #2 did not have bath entries or refusals recorded on the electronic medical record for 2/28/2026, 3/5/2026, 3/7/2026, 3/10/2026, 3/12/2026, 3/14/2026, 3/17/2026, and 3/24/2026. During an observation and interview on 3/26/2026 at 10:45 AM, Resident #2 was observed in their room with clean clothes and a groomed appearance. He stated I have to have help with showers. During an interview on 3/27/26 at 3:03 PM, CNA A revealed that showers were required to be documented in the POC. She said for me, when we are really busy, I don't chart. I always offer residents a shower. She revealed reasons for not marking a shower or refusal on the EMR was due to being busy and hectic when I have to provide care for 30+ residents. During an interview on 3/27/26 at 2:48 PM, CNA B stated that shower documentation was in the system. We can hit the tub icon and document PRN or scheduled shower. I have to fill it out. She revealed that the resident (Resident #2) probably refused the scheduled shower. During an interview on 3/27/26 at 5:55 PM, the DON revealed that showers were required to be documented. She stated that the process for shower refusals was the CNA asks and alerts the nurse if refused, the nurse will walk in with the CNA to offer, if still no, they try again later and document as a refusal if not wanted. Record Review of a facility policy, Nail Care, undated, (continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>revealed: Documentation Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident and or soft resident file. It may include observations, investigations, and communications of the resident involving care and treatments. It has legal requirements regarding accuracy and completeness, legibility, and timing. Special forms in the clinical record are utilized in nursing documentation, such as assessment, care plan, nursing progress notes, flow sheets, medication sheets, incident reports, and summary sheets (daily, weekly, monthly, discharge). Documentation also occurs in the clinical software Point Click Care (PCC). Goal 1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.2. The facility will ensure that information is comprehensive and timely and properly signed.</p>		