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	05/06/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had a right to confidentiality of his or her personal and medical records for one (1) of six (6) residents (Resident #1) reviewed for privacy and confidentiality. The facility failed to ensure Resident #2's medical records did not contain Resident #1's Administration Report prior to the release of Resident #2's records, dated 04/28/2026, to Resident #2's family member. This deficient practice could place residents at risk of their medical information being accessed by unauthorized individuals. The findings included: Record review of Resident #1's admission Record, dated 05/05/2026, revealed a [AGE] year-old male. He was admitted on [DATE]. Record review of Resident #1's Diagnosis Report, dated 05/05/2026, revealed diagnoses included other sequelae (a condition following a previous disease or injury) following unspecified cerebrovascular disease (a group of conditions that affect the blood flow and blood vessels in the brain), cognitive communication deficit (difficulty communicating due to injury to the brain), and cerebral infarction (a disruption in the brain's blood flow). Record review of Resident #1's Quarterly MDS Assessment, dated 04/08/2026, revealed the resident had a BIMS Score of 11, indicating he was moderately cognitively impaired. He was documented to have fluctuating inattention and disorganized thinking (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject). Record review of Resident #2's admission Record, dated 05/05/2026, revealed an [AGE] year-old female. She was initially admitted on [DATE], re-admitted on [DATE], and discharged on 03/19/2026. A family member was listed under Contacts as an Emergency Contact. During an interview on 05/05/2026 at 09:07 a.m., Resident #2's family member stated she had requested Resident #2's medical records. She stated upon receiving and reviewing Resident #2's medical records she found one document among Resident #2's records that was on another resident. Record review of a photo submitted by Resident #2's family member on 05/05/2026 at 09:41 a.m. The photo revealed how Resident #2's medical record files were listed on the USB she had received from Nursing Facility A. The files visible in the image were noted to be dated 04/28/2026 at 12:27 p.m. Record review of a photo submitted by Resident #2's family member submitted 05/05/2026 at 10:00 a.m. The photo revealed a printed copy of Resident #1's Administration Record, dated 03/11/2026. The document included Resident #2's name, date of birth , admission dates, insurance type and policy number, and care providers names. The photo submitted was one page and did not include Resident #1's social security number or diagnosis list. During an interview on 05/05/2026 at 03:56 p.m., the MR staff member stated she provided Resident #2's family member with a USB uploaded with Resident #2's medical records after obtaining approval to release the information. She stated per her standard process, she had reviewed the first 15- 17 pages of each file uploaded to the USB to confirm the documents were from Resident #2's profile in the EMR. She stated the ADMIN had notified her on 05/01/2026 that Resident #2's family member told him that another resident's information was in the released documents. She stated upon re-reviewing the released Resident #2 medical record file, on 05/05/2026, she found one document, titled under physician's orders. It was another resident's administration record. She stated she notified the administrator of her finding. She stated she did not know how the other resident's document was (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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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	uploaded into Resident #2's profile. She stated she believed someone uploaded the wrong document to Resident #2's profile. She stated the error could easily happen. She stated she was unsure if Resident #1 was contacted about the error. She stated the other resident's document (Resident #2's Administration Record) contained his personal information, including his date of birth , resident representative information, and insurance information. She stated for the resident, this type of error could be considered a huge thing. She stated the information was confidential. She stated she understood Resident #2's family member was upset upon finding another resident's document. She stated she had not spoken to Resident #1 about the incident. During an interview on 05/06/2026 at 10:36 a.m., when asked how he felt about his medical and insurance information having been sent to another resident's family member, Resident #1 stated he would not like it but thought it would have been hard to get. He stated he would have been concerned about the information having been used but did not believe the information would have been released. Resident #1 stated he had not been told anything by Nursing Facility A and felt safe. During an interview on 05/06/2026 at 01:18 p.m., the DON stated she had not been notified of any resident's information having been released. She stated she did not deal with medical records. She stated the MR staff member was responsible for releasing medical records. She stated if there was an error, she was not sure who was responsible, but she assumed it would be the ADMIN. She stated the impact of a resident's medical information having been released was it was the resident's personal information and the information would be open for another person who should not have received it. During an interview on 05/06/2026 at 02:00 p.m., the ADMIN stated he was notified by Resident #2's family member that another resident's information was included in the medical records provided to her for Resident #2. He stated he asked Resident #2 to bring the USB back to be exchanged with a new USB, so the other resident's information could be removed. He stated that the MR staff member notified him today, 05/06/2026, that the other resident's document was Resident #1's Administration Record. He stated, when Resident #1 was admitted , his Administration Record was probably accidentally scanned to Resident #2's profile. He stated the impact of the document having been released was that it was a violation of personal information. He stated he was trying to give Resident #2's family member a new USB to correct the error. He stated he had not spoken with Resident #1 personally but was planning on letting him know. Record review of facility policy Resident Rights, undated, revealed: Privacy and confidentiality- The resident has the right to personal privacy and confidentiality of his or her personal and medical records. 3. The resident has a right to secure and confidential personal and medical records. a. The resident has the right to refuse the release of personal and medical records except as provided at S483.70(i)(2) or other applicable federal or state laws.