

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
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 06/04/2026
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation was implemented for 2 of 3 residents (Resident #1 and Resident #2) reviewed for pharmacy services. The facility failed to ensure narcotic medications were accurately documented and reconciled on 5/29/26, 5/31/26, 6/1/26, and 6/2/26 for Resident #1 and 5/26/26, 5/28/26, 5/29/26, and 5/31/26 for Resident #2. These failures could result in the loss of residents' property, diversion of narcotics, and residents not receiving intended medication regimens. Findings included: Record review of Resident #1's admission Record dated 6/02/2026 reflected a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included paraplegia (partial or complete paralysis of the lower extremities). Record review of Resident #1's admission MDS dated [DATE] reflected a BIMS score of 14, which indicated intact cognition. MDS revealed Resident #1 presented with occasional pain within the past 5 days. Resident pain intensity was documented as a 2 on a scale of 0 out of 10 and received pain medication regimen. Record review of Resident #1's Care Plan Report undated/ printed 6/02/2026, reflected the following: The resident has a potential for uncontrolled pain. Date Initiated: 3/27/2026 Record review of Resident #1's Order Summary Report dated 6/02/2026, reflected the following order dated 4/20/2026: oxycodone [sic] HCl Oral Tablet 5 MG (Oxycodone HCl) Give 1 tablet by mouth every 8 hours as needed for pain Record review of Resident #1's May 2026 Treatment Administration Record, dated 6/02/2026, for Resident #1's oxycodone 5mg tablet administration reflected the following were not documented as administered on the following dates: 5/29/2026 at 4:30 PM, 1 dose of oxycodone 5mg removed by illegible staff signature 5/31/2026 at 2:00 PM, 1 dose of oxycodone 5mg removed by illegible staff signature 5/31/2026 at 10:10 PM, 1 dose of oxycodone 5mg removed by illegible staff signature 6/1/2026 at 9:00 PM, 1 dose of oxycodone 5 mg removed by illegible staff signature Record review of Resident #1's June 2026 Treatment Administration Record, dated 6/02/2026, for oxycodone 5mg tablet administration reflected on 6/2/2026 12:43 PM, 1 dose of oxycodone 5mg documented as administered by LVN A on the June 2026 TAR. Record review of untitled facility document dated 5/29/2026 used to track Resident #1's oxycodone 5mg tablet administration reflected the following: 1. 5/29/2026 at 4:30 PM, 1 dose of oxycodone 5mg removed by illegible staff signature. 2. 5/31/2026 at 2:00 PM, 1 dose of oxycodone 5mg removed by illegible staff signature. 3. 5/31/2026 at 10:10 PM, 1 dose of oxycodone 5mg removed by illegible staff signature. 4. 6/1/2026 at 9:00 PM, 1 dose of oxycodone 5mg removed by illegible staff signature. 5. 6/2/2026 12:43 PM, 1 dose of oxycodone 5mg was not documented as removed on the narcotic tracking document. Further review revealed the remaining total count of tablets noted by final entry on the narcotic tracking document was entered as 7 by the entry dated 6/2/2026 at 04:00 AM. In an observation on 6/2/2026 at 3:40 PM, a blister pack identified on the pharmacy label as oxycodone 5mg tablets belonging to Resident #1 contained 6 total tablets. In an interview on 6/04/2026 at 9:55 AM, Resident #1 said she had no concerns about the administration of her pain medication. She said she had received a dose whenever she asked for it within the window of administration time, and she (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	did not have concerns that she was receiving a medication other than what was prescribed to her. Record review of Resident #2's admission Record dated 6/03/2026 reflected an [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE]. Relevant diagnoses included chronic pain syndrome (when a person feels continuous, ongoing pain). Record review of Resident #2's admission MDS dated [DATE] reflected a BIMS score of 15, which indicated intact cognition. MDS revealed resident received pain medication regimen within the last 5 days and the resident had not presented with pain within the last 5 days. Record review of Resident #2's Care Plan Summary undated, printed 6/03/2026, reflected the following: The resident is on Pain [sic] medication Therapy [sic] Date Initiated 5/07/2026 Record review of Resident #2's Order Summary Report dated 6/03/2026 reflected the following order dated 5/14/2026: HYDROMORPHONE [sic] HCl Oral Tablet 2mg (Hydromorphone HCl) Give 0.5 tablet by mouth every 6 hours as needed for pain 1/2 tablet equals 1mg Record review of Resident #2's Treatment Administration Record for May 2026 dated 6/02/2026, for Resident #2's hydromorphone 2mg tablet administration reflected the following: 5/26/2026: TAR reflected 2 total doses were administered on 5/26/2026 at 1:15 PM and 7:21 PM, both by LVN A. 5/28/2026: TAR reflected 2 total doses were administered on 5/28/2026 at 5:40 AM by LVN B and 6:55 PM by LVN A. 5/29/2026: TAR reflected 1 dose was administered on 5/29/2026 by LVN C at 12:02 PM. 5/31/2026: TAR reflected 1 dose of hydromorphone 2mg was administered on 5/31/2026 at by LVN D at 7:46 AM. Record review of the untitled facility document dated 5/15/2026 used to track Resident #2's hydromorphone 2mg tablet administration reflected the following: 1. 5/26/2026: 3 total doses of hydromorphone 2mg tablets were removed at 3:00 AM, 9:00 PM, and 9:00 PM by illegible staff signatures. 2. 5/28/2026: 3 total doses of hydromorphone 2mg tablets were removed at 3:40 AM, 1:00 PM, and 9:00 PM by illegible staff signatures. 3. 5/29/2026: 2 total doses of hydromorphone 2mg tablets were removed at 12:00 PM and 9:00 PM by illegible staff signatures. 4. 5/31/2026: 2 total doses of hydromorphone 2mg tags were removed at 7:46 AM and 3:14 PM by illegible staff signatures. Further review revealed that the remaining total count of tablets noted by final entry on the narcotic tracking document was entered as 22 by the entry dated 6/2/2026 at 03:00 AM. In an observation on 6/02/2026 at 3:40 PM, the blister pack identified as containing Resident #2's hydromorphone 2mg tablets by the pharmacy label was observed to contain 21 tablets. In an interview on 6/04/2026 at 9:40 AM, Resident #2 said she had no concerns or issues regarding administration of her pain medication. She said she received the medication when she requested it, and the pill always looked the same. In an interview with LVN A on 6/2/2026 at 3:45 PM, she said she was responsible for many or most of the discrepancies in Resident #1 and Resident #2's narcotic records. She declined to review each discrepancy individually. She said she frequently forgot to document in the TAR when she administered pain medications, and she said she had not yet documented medications removed from the blister packs for Resident #1 and Resident #2, which was why there was a discrepancy in the count during the observation on 6/2/2026 at 3:40 PM. She said the inconsistencies for both residents were documentation only, and the medications had been administered. She denied diverting narcotic medications from the residents. She said the facility policy was to document in the TAR and on the tracking document as the medications are administered, but she often forgot. In an interview with the DON on 6/2/2026 at 3:55 PM, she the facility policy was to document narcotics both in the TAR and on the tracking document at the time the medications are administered. She said LVN A was aware of the policy and had been trained, and she was unaware LVN A had been deviating from the policy. She said the potential harm of inaccurate documentation was missing medications or residents not receiving their medications. Record review of the facility policy Medication Administration and General Guidelines dated 2025 reflected the following: .9. Except for single unit dose packet distribution systems, only the licensed or legally authorized personnel who prepare a medication may administer it. This person then records the administration on the residents [sic] MAR at the time the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ascertain that all (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	necessary doses were administered and documented. In no case should the individual who administered the medications report off duty without first recording the administration of any medications .		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for dietary services. The facility failed to ensure the kitchen was free from insects in the dry storage area and standing water in the walk-in refrigerator and freezer areas on 6/03/2026. This failure could lead to food contamination and illness. Findings included: In an observation of the kitchen, on 6/03/2026 at 10:54 AM, revealed the following; Two dead insects were observed in the dry storage area of the facility, underneath wire storage racks. A large, gray, plastic tub without a lid was observed in the walk-in fridge. The tub held a sealed bag of yellow food product. A moderate amount of loose, brown water was also observed in the bottom tub. In the walk-in freezer, icicles were noted to be frozen on the sprinkler head, and a thin layer of ice coated one corner of the freezer beneath the wire storage racks. In an interview on 6/03/2026 at 11:15 AM, she said the kitchen staff was responsible for sweeping underneath the storage racks in the dry storage room every evening. She attributed the brown water in the gray tub located in the walk-in refrigerator to the sprinkler head located above the wire rack. She said the sprinkler head was known to leak water into the refrigerator and cooler areas after it rained, and she said that was also why there were icicles on the sprinkler head and ice on the floor in the walk-in freezer. She said she had not notified the Maint. Dir. or Admin. of the possible leaking sprinkler heads. In an interview with the Maint. Dir. on 6/03/2026 at 11:30 AM, he said a different sprinkler head had been repaired at the facility a couple of days prior, but he was not aware there were any leaks in the kitchen. He also said the facility's contracted pest control company had been to the facility multiple times in the past month for reports of insects from residents, but they had no findings in the kitchen areas. Record review of the facility policy titled Food Storage and Supplies dated 2012 reflected the following: All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. We will ensure storage areas are clean, organized, dry and protected from vermin, [sic] and insects. Storeroom floors should be swept and mopped to be maintained in a sanitary manner to prevent vermin or pest infestation.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were provided a sanitary and comfortable environment for 1 of 8 residents (Resident #3) reviewed for physical environment. The facility failed to ensure Resident #3's room was free from dead insects and had hot water available through the hand sink. These failures could lead to decreased quality of life. Findings included: Record review of Resident #3's admission Record dated 6/02/2026 reflected an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included acquired absence of unspecified leg below knee (surgical procedure to remove the lower leg). Record review of Resident #3's admission MDS submitted 5/15/2026 reflected a BIMS score of 14, which indicated intact cognition. In an observation of Resident #3's room, on 6/03/2026 at 10:00 AM, revealed the following: was observed to have multiple, disposable insect traps on the floor along the perimeter of the room. One of the disposable traps was observed to contain a dead insect. Additionally, the hot water tap from the hand sink measured at 77.1 degrees Fahrenheit after continuous flow for 1 minute. The temperature of the water was 77.3 degrees Fahrenheit after 4 minutes of continuous flow, and 78 degrees Fahrenheit after 8 minutes. In an interview and observation on 6/03/2026 at 10:00 AM, Resident #3 said the sink in her room has not consistently had hot water since she arrived at the facility. She said her private caregivers are able to obtain hot water from the shower room down the hall to assist her with personal care, but it was inconvenient. She said she had reported this issue to the nursing staff. She also said she frequently sees insects crawling on the walls and ceilings at night, and an exterminator had come to spray something in her room earlier in the week, but the infestation continued. She said the disposable insect traps contained dead insects and had been in place for multiple weeks. She said knowing the traps contained dead bugs made her feel disgusted. There were no live insects observed in the resident's room, closet, or bathroom. In an interview with the Maint. Dir. on 6/03/2026 at 10:30 AM, he said he was aware the hallway where Resident #3 resided intermittently experienced hot water issues. He said he had previously made adjustments to the device that circulates hot water, and he had not been notified of any issues since then. The Maint. Dir. said he was aware of complaints from Resident #3 regarding insect infestation, and the contracted exterminator had been to the facility several times in the last month to perform inspections and treatment. He also said the disposable insect traps were placed earlier that week by the exterminator, and the facility was instructed to leave the traps in place so they could be inspected and removed by the exterminator for further treatment. He was unsure when the exterminator was due to remove the traps, but he was unaware the traps in Resident #3's room contained dead insects or that she wanted them removed. In an interview with the Admin. on 6/04/2026 at 12:20 PM, he said he was previously unaware of the hot water issue in Resident #3's room, and the facility was already working on replacing the circulator device to ensure all residents had continuous hot water on demand. He was also previously unaware of the disposable glue traps placed in Resident #3's room, and he said he would have them removed to ensure her comfort. Record review of an invoice #142195 dated 5/19/2026 reflected the following: Called the Maintenance Director, [Maint. Dir.], who said [Resident #3's room] was the only issue. He reported that resident saw a large flying roach on the wall. [Maint. Dir.] couldn't find any evidence of activity. [Resident #3's room]: Resident reported the same info to me as [Maint. Dir.]. No activity found at time of inspection. Treated bathroom with a liquid residual. Placed monitoring stations with roach bait throughout the rest of the room. A policy related to environmental concerns and homelike environment was requested from the facility, and in an interview on 6/04/2026 at 1:20 PM, the Admin. said these concerns are covered within the facility's policy regarding resident rights. Record review of the facility policy titled Resident Rights revised 11/28/2016 reflected the following: Respect and (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dignity- The resident has a right to be treated with respect and dignity, including: . The right to resident 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 .		