| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676216 | A. Building<br>B. Wing | 11/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Remington Transitional Care of San Antonio | 5423 Hamilton Wolfe Rd<br>San Antonio, TX 78229 |

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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>(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 |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676216 | A. Building<br>B. Wing | 11/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Remington Transitional Care of San Antonio | 5423 Hamilton Wolfe Rd<br>San Antonio, TX 78229 |

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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 1 (Resident # 1) of 5 residents reviewed for MDS accuracy. Resident #1's re-entry MDS assessment from the hospital did not reflect the fall which resulted in a fracture and was the reason she went to the hospital. This failure affects residents who reside at the facility and could result in missed care.The findings included: Record review of Resident #1's electronic face sheet dated 11/18/2025 reflected she was an [AGE] year-old female who was originally admitted to the facility on [DATE], fell at the facility which resulted in a fracture, and she was sent to the hospital on [DATE]. She was then readmitted to the facility from the hospital on [DATE]. Her diagnoses included: fracture of the upper end of right humerus (upper arm bone), metabolic encephalopathy (diffuse brain dysfunction that can lead to confusion, memory loss and loss of consciousness) and chronic kidney disease (kidneys have become damaged over time and can lead to increased risks of other health issues such as heart disease and stroke). Record review of Resident #1's MDS admission re-entry assessment dated [DATE] reflected she could understand and be understood. She required maximum assistance with her care. She scored 12 of 15 on her BIMS which indicated her cognitive status was moderately impaired. Review of section J1700. Fall History on Admission/Entry or Reentry inaccurately reflected Resident #1 did not have any fall in the last month prior to admission/entry or reentry. Record review of Resident #1's comprehensive care plan dated 10/29/2025 reflected under Focus, the resident has had an actual fall due to poor balance and an unsteady gait. Record review of Resident #1's incident report titled unwitnessed fall dated 10/29/2025 at 11:53 pm reflected was found on the floor by door. Patient was lying on her right side. Record review of the hospital record dated 10/30/2025 reflected patient fell when she was tying to get out of bed. She landed on her right hip. Observation on 11/18/2025 at 12:13 pm, Resident #1 was dressed in a hospital gown, and she wore a brief and was lying in bed in her room. The bed was in a low position; the call light was next to her on the bed. During an interview on 11/18/2025 at 12:15 pm, Resident #1 stated that she had a fall trying to get out of bed and did not remember to use her call light to call for assistance. During an interview on 11/18/2025 at 12:40 pm, the DON stated Resident #1 had a fall in the facility on 10/29/2025 and was sent to the hospital where she was found to have a fractured femur. He stated the fall should have been reflected on her re-entry MDS to reflect her actual condition which led to her care and the development or updating of her care plan. He stated the care she required could be missed with an inaccurate MDS. During an interview on 11/18/2025 at 2:18 pm, LVN A stated she completed Resident #1's re-entry MDS and she did not know why she missed coding her fall. She stated she updated the resident's care plan and still missed checking off on her MDS that she had a fall. She stated that an inaccurate care plan could result in missed care for a resident. During an interview on 11/18/2025 at 2:56 pm, the ADM stated she was accountable for the MDS assessments, and she stated she did not know how LVN A missed the fall, and she stated that the MDS assessment was directly related to a resident's care plan and a resident could miss care if the MDS was not correct. Review of the CMS Long Term Care RAI 3.0 User's Manual Version 1.20.1, October 2025 reflected The RAI process has multiple regulatory requirements. Federal regulations require that (1) the assessment accurately reflects the resident's status. Code 1, yes: if resident or family report or transfer records or medical records document a fall in the month preceding the resident's entry date item (A1600). |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676216 | A. Building<br>B. Wing | 11/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Remington Transitional Care of San Antonio | 5423 Hamilton Wolfe Rd<br>San Antonio, TX 78229 |

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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676216 | A. Building<br>B. Wing | 11/18/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Remington Transitional Care of San Antonio | 5423 Hamilton Wolfe Rd<br>San Antonio, TX 78229 |

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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for 1 (Resident #2) of 5 residents reviewed for implementation of care plans. Resident #2 did not have a floor mat on each side of his bed as was specified in his comprehensive plan of care for fall prevention. This failure affects residents at high risk for falls and could result in injury or disability. The findings included: Record review of Resident #2's electronic face sheet dated 11/18/2025 reflected he was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included: displaced fracture of the left femur (type of fracture where the bone has broken and is out of alignment from its original position), atherosclerotic heart disease (characterized by plaque buildup in the artery walls which can restrict blood flow and lead to heart attacks or strokes), bipolar disorder (characterized by extreme mood swings that include emotional highs and lows), dementia (loss of cognitive functioning), and anxiety (feeling of worry, nervousness, or unease). Record review of Resident #2's 5-day scheduled assessment MDS dated [DATE] reflected he could understand and be understood. He scored 12 of 15 on his BIMS which signified his cognitive status was moderately impaired. He required extensive assistance with ADLs. He had a fall in the previous month prior to admission or reentry. Record review of Resident #2's comprehensive care plan dated 09/08/2025 reflected Problem, is at risk for falls, Interventions, keep the bed in the low position as tolerated place fall mats at the sides of the bed. Record review of Resident #2's Kardex (communication form used by CNAs to tell them what care needed to be provided) as of 11/18/2025 reflected Safety, place fall mats at the sides of the bed. Record review of facility tracking and trending log from September to November 2025 reflected Resident #2 had one witnessed fall and 6 unwitnessed falls without injury. Observation on 11/18/2025 at 10:32 am of Resident #2 revealed he was in his room lying in bed, family member at his side. He had a fall mat on the floor on the right side of his bed; no other floor mat was observed to be in his room. During an interview on 11/18/2025 at 10:33 am with Resident #2's family member, she stated Resident #2 had a fall at home and broke his leg and that was why he was at the facility for rehabilitation. She stated he would be discharged from the facility to an ALF because he has had numerous falls, and his safety concerned her. Observation on 11/18/2025 at 12:30 pm of Resident #2 accompanied by the DON revealed Resident #1 was lying in bed eating lunch and there was one mat on the floor on the right side of the bed. The DON confirmed there was not a floor mat on the left side of the bed. During an interview on 11/18/2025 at 12:35 pm, Resident #2 stated he had falls and when questioned by the DON if he had falls on one side of the bed, he responded no, I fall off both sides of the bed. During an interview on 11/18/2025 at 12:40 pm, the DON stated it was important to implement interventions in the care plan because that was what was assessed to be the care a resident needed. He stated Resident #2 could fall on the floor without the mat and even with a low bed could sustain injury from landing on the floor. During an interview on 11/18/2025 at 1:32 pm, RN B stated she was the charge nurse on Resident #2's hall and she did rounds but did not notice he did not have floor mat on each side of the bed. She stated she did not know why she did not notice. She stated she would get a mat right away because it was important in case he fell from the bed to prevent or minimize injury. She stated she had access to Resident #2's care plan and nurses passed notes about residents needed care at shift change. During an interview on 11/18/2025 at 2:18 pm, CNA C stated she was the CNA for Resident #2 and did not notice he did not have a floor mat on each side of the bed. She stated she used the Kardex to see what a resident needed for care and safety. She stated she reviewed Resident #2's Kardex. She stated it was important to have a mat on each side of the bed for Resident #2 to prevent injury from falling. During an interview on 11/18/2025 at 2:56 pm, the ADM stated she did round on residents and expected staff to implement care plan interventions because it was what was assessed for a resident to meet their needs. Record review of the facility policy and procedure titled Comprehensive Care Plans dated 10/224/2022 reflected, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment. Record review of the facility policy and procedure titled Fall Prevention Program dated 08/15/2022 reflected Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care, interventions will be monitored for effectiveness, and the plan of care will be revised as needed |