| 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 | 12/15/2025 |

| 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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<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 | 12/15/2025 |

| 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 0842<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 interview and record review, in accordance with accepted professional standards and practices, the facility failed to maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized for one (1) of five (5) residents (Resident #1) reviewed for clinical records. The facility failed to ensure RN A documented a repeat blood pressure level when the initial level was below the approved range to administer Metoprolol Succinate (a blood pressure medication). This failure could place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records. The findings included: Record review of Resident #1's admission Record, dated 12/13/2025, revealed a [AGE] year-old male admitted on [DATE]. Resident #1 was listed as his own responsible party with his [family member] listed a secondary contact. Resident #1 discharged on 12/09/2025. Record review of Resident #1's EMR Medical Diagnosis tab, undated and accessed 12/13/2025 at 10:58 a.m., revealed diagnoses including encounter for orthopedic (the branch of medicine dealing with conditions affecting the bones or muscles) aftercare following surgical amputation (the action of cutting off a limb, such as a leg below the knee), heart failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs), and hypertension ( a chronic condition where the pressure in the body's blood vessels is consistently too high). Record review of Resident #1's discharge with return anticipated MDS, dated [DATE] and signed 12/11/2025 as completed, did not reflect Resident #1's mental status score. Resident #1's functional abilities were documented as requiring partial/moderate assistance for transfers. Record review of Resident #1's Brief Interview for Mental Status, dated effective 11/27/2025, reflected Resident #1 had a memory problem and was moderately impaired regarding making decisions for daily life. Record review of Resident #1's Order Recap Report, dated 12/13/2025 for orders dated 11/26/2025- 12/09/2025, reflected the physician order Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG (Metoprolol Succinate) Give 1 tablet by mouth one time a day for HTN HOLD IF SBP < 100, DBP < 60, or HR < 60. The order was noted as dated 11/26/2025 with start date 12/27/2025 and end date 12/12/2025. Record review of Resident #1's Skilled Administration Record, dated 12/01/2025- 12/31/2025, reflected the order Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG (Metoprolol Succinate) Give 1 tablet by mouth one time a day for HTN HOLD IF SBP < 100, DBP < 60, or HR < 60. The administration record indicated the medication was administered on 12/02/2025 by RN A. The hours of administration were documented as *6a 1. The blood pressure and pulse values for 12/02/2025 were documented as NA. NA was not defined on the record. Record review of Resident #1's EMR Blood Presssure tab, undated and accessed 12/13/2025 at 11:33 a.m., revealed two (2) blood pressure values for 12/02/2025, 127/57 mmHg by RN A at 07:04 a.m. and 150/69 mmHg by 09:26 p.m. by LPN B. Record review of Resident #1's progress notes dated 11/13/2025- 12/14/2025 did not reveal a progress note regarding the provision of Metoprolol Succinate on 12/02/2025 or a reassessment of Resident #1's blood pressure. Resident #1 was unavailable on 12/14/2025 and 12/15/2025 for observation or interview due to his status as an in-patient at a local military hospital that does not allow visitation. During an interview on 12/14/2025 at 10:42 a.m., Resident #1's family member and listed contact stated she had concerns regarding Resident #1's blood pressure treatment at a prior facility, but she did not reveal concerns regarding his blood pressure treatment at the facility he discharged from on 12/09/2025. During an interview on 12/15/2025 at 03:13 p.m., MD C stated he was providing care to Resident #1 while the resident was admitted to the facility. MD C denied having had received notification of Resident #1's blood pressure having been below administration range for the Metoprolol Succinate order. MD C stated he did not have concerns if RN A had administered Resident #1 the Metoprolol Succinate on 12/02/2025 if the DBP was at 57 mmHg and below the hold order. MD C stated the only impact would have been that Resident #1 could have experienced some dizziness. During an interview on 12/15/2025 at 03:35 p.m., RN A stated she couldn't recall administering Resident #1 his Metoprolol Succinate on 12/02/2025 but stated she probably re-checked Resident #1's blood pressure prior to administering since the initial DBP was outside the administration range. She stated she would re-check a resident's blood pressure if the values seemed outside the resident's normal range or were outside the administration range. She stated, if she had re-checked Resident #1's blood pressure, she probably didn't document the new values. She stated the impact of not documenting the new values was that the administration would show as a medication error. She stated she was aware the |