

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2025
NAME OF PROVIDER OR SUPPLIER Pecan Valley Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 3838 E Southcross Blvd San Antonio, TX 78222	
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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure the residents had the right to voice grievances to include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay, for 2 of 8 residents (Residents #1 and #2) reviewed for grievances.</p> <p>On 11/9/2024 Resident #1 made a grievance to Medication Aide A (MA A) which she did not document or report to the DON. The grievance alleged he did not receive medications on 11/8/2024.</p> <p>On 11/19/2024 Resident #2 made a grievance to Case Manager D (CM D) which she did not document or report to the DON. Resident #2 alleged he was left at the doctor's office for hours without return home transportation.</p> <p>These failures could place residents at risk for harm by leaving residents with frustration and demoralization.</p> <p>The findings included:</p> <p>1. A record review of Resident #1's admission record dated 5/7/2025 revealed Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included blindness, diabetes (high blood sugar concentration which impairs the body functions and could cause blindness and kidney injuries), and chronic kidney disease.</p> <p>A record review of Resident #1's medication administration records for 11/1/2024 through 11/30/2024 revealed Resident #1 received all medications prescribed to him throughout November 2024.</p> <p>A record review of the state regulatory agency's complaint intake dated Wednesday 11/13/2024 revealed Resident called the state regulatory agency to allege he did not receive his medications on Saturday 11/9/2024.</p> <p>A record review of the facility's grievance reports for the month of November 2024 revealed no grievances for Resident #1 regarding not receiving medications.</p> <p>(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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/7/2025 at 9:20 AM Resident #1 stated he has had many grievances against the facility and does not recall the specific grievance he reported in November 2024 but did recall he did not receive medications during a weekend in November 2024. Resident #1 stated he usually received his medications from MA A but she did not work the weekends and most likely MA A and the nurses would have been the staff who would have heard his grievances concerning the staff on the weekends. Resident #1 stated no one has addressed his concerns for the weekend staff.</p> <p>During an interview on 5/7/2025 at 11:20 AM MA A stated she recalled Resident #1 sometime in November 2024, on a Monday, had made a complaint that the weekend nurse had not administered his medications over the weekend. MA A stated she believed she had not documented a grievance report but had reported the complaint to the weekday nurse she usually worked with, LVN B.</p> <p>During an interview on 5/7/2025 at 4:20 PM LVN B stated she had a good rapport with Resident #1 and MA A. LVN B stated she could not recall if she had received a report from Resident #1 or MA A related to Resident #1 not receiving his medications. LVN B stated had she heard a report of Resident #1 not receiving his medications she would investigate and report the concern to the DON and would have documented a grievance report.</p> <p>2. A record review of Resident #2's admission record dated 5/9/2025 revealed Resident #2 was an [AGE] year-old male admitted to the facility on [DATE], with diagnoses which included atherosclerotic heart disease (a hardening of the arteries from plaque buildup), dementia (a group of symptoms affecting memory, thinking and social abilities which interfere with activities of daily life), and difficulty walking.</p> <p>A record review of the facility's grievance reports for the month of November 2024 revealed no grievances for Resident #2 regarding being left at the doctor's office for hours.</p> <p>A record review of Resident #2's nursing note dated 11/19/2024 revealed LVN G documented at 2:16 PM, Resident returned from cardiology appointment</p> <p>During an interview on 5/6/2025 at 1:41 PM, Resident #2's representative stated, on 11/19/2024 Resident #2 went to the cardiologist's physician's assistant office for an early morning appointment and after the appointment was confused by the doctor's staff as to where to await the return to home transport and consequently waited for hours within the clinic and missed his transport. Resident #2's representative stated Resident #2 used his cell phone to call family and the family coordinated a pickup and transported Resident #2 back to the facility that afternoon. Resident #2's representative stated she and Resident #2 made a grievance to CM D concerning Resident #2's missed transportation and lack of assistance for hours. Resident #2's representative stated the facility had not responded to the grievance.</p> <p>During an interview on 5/7/2025 at 11:29 AM CM D stated she recalled Resident #2 was upset because his Family member was late to pick him up after a doctor's appointment. CM D stated she could not recall if she received a complaint from Resident #2's representative. CM D stated she did not document Resident #2's complaint on a grievance report but she recalled speaking to Resident #2's representative about the late return to the facility. CM D stated, I don't remember what month, but the incident was around fall 2024.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/9/2025 at 9:23 AM the Administrator and the DON stated they had not received a report on behalf of Resident #1 from November 2024 alleging he did not receive medications nor Resident #2's complaint of missing his return to the facility transport after his cardiology appointment. The Administrator and the DON stated the expectation was all residents who communicated grievances had their grievances heard and for staff to follow the grievance process and at a minimum document a grievance report which would have been reviewed and investigated by the facility leadership. The Administrator and the DON stated the potential risk to residents was their grievances would go unrecognized and unresolved.</p> <p>A record review of the facility's Grievance policy dated June 2023, revealed, It is the policy of this facility to establish a grievance process that allows the resident(s) a way to execute their right to voice concerns or grievances to the facility or other agency/entity without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their facility stay. The facility will make information on how to file a grievance available to the residents and make prompt efforts to resolve grievances that the resident may have.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure that residents received treatments and care in accordance with professional standards of practice and the residents' choices for 1 of 8 residents (Resident #3) reviewed for quality of care.</p> <p>Resident #3 had a cardiology appointment on 11/13/2024, for an echocardiogram (an exam which uses sound waves to make pictures of the heart), and the facility failed to attempt to provide a chaperone to the appointment when her representative was late; subsequently Resident #3 missed her appointment.</p> <p>This failure could place residents at risk for decreased quality of care due to delayed health status reports to the physicians.</p> <p>The findings included:</p> <p>A record review of Resident #3's admission record dated 5/7/2025 revealed Resident #3 was a [AGE] year-old female admitted [DATE] with diagnoses which included heart failure, cardiomegaly (enlarged heart), and need for assistance with personal care.</p> <p>A record review of Resident #3's physicians order dated 10/28/2024 revealed Resident #3 was scheduled to see her cardiologist on 11/13/2024 at 1:00 PM. Further review revealed the scheduled ambulance pick up was scheduled for noon and Resident #3 was to be escorted by her representative.</p> <p>A record review of Resident #3's nursing notes dated 11/13/2024 at 2:43 PM, revealed LVN F documented Resident #3 missed her cardiology appointment due to Resident #3's representative did not arrive to accompany Resident #3 to her cardiology appointment, The patient had an appointment today. Transportation arrived at the facility one hour prior to the appointment. The patient was cleaned and positioned in her wheelchair and sat by the nursing station awaiting on her [Resident #3's Representative] who was going to escort the patient to the appointment. Writer called the [Resident #3's Representative] several of times, to see if she was going to meet [Resident #3] here or at the doctor's office, but she did not answer. The [Resident #3's Representative] arrived at the facility at 1:40 pm. Requested the number to the Transportation service she was given the number then walked away to [Resident #3's] room.</p> <p>During an interview on 5/7/2025 at 3:01 PM Resident #3 Representative stated she usually accompanies Resident #3 to all her medical appointments. However, on 11/19/2024 she was delayed and arrived at the facility to accompany Resident #3 to her cardiologist appointment and discovered LVN F had dismissed the ambulance and cancelled the cardiologist appointment without attempting to support Resident #3 to attend her cardiologist appointment and did not attempt to send a staff member with Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/8/2025 at 11:28 AM ADON E stated the facility's system for appointment coordination had multiple data input points to include appointment information from residents, representatives, doctors, nurses, staff, and the data was recorded on a worksheet and entered into the medical record as an order to be populated on the medication administration record. ADON E stated she was informed Resident #3 missed her cardiology appointment on 11/13/2024 after the missed appointment. ADON E stated had she been given a report she would have tried to organize a chaperone for Resident #3 to attend her appointment.</p> <p>During an interview on 5/8/2025 at 11:40 AM LVN F stated the usual routine for resident's appointments was coordinated by the facility to have transportation take residents to the appointments and if needed the Resident would be chaperoned by a staff member, usually CNA C. LVN F stated all nursing staff could coordinate transportation for residents, but CNA C also assisted to plan transportation for residents. LVN F stated she recalled the incident when Resident #3's representative had not arrived on time to accompany Resident #3 to her cardiologist's appointment. LVN F stated, I don't remember what month, but it was a couple of months ago. LVN F stated Resident #3 could not attend any appointment by herself and needed supervision for safety. LVN F stated the contracted ambulance service waited for Resident #3's representative to arrive to accompany Resident #3 to her appointment but could not wait for an extended time due to scheduling conflicts. LVN F stated she was unsuccessful in contacting Resident #3's representative with phone calls and after 20 to 40 minutes of waiting for Resident #3's representative to arrive she dismissed the ambulance. LVN stated she had not reported the incident to her supervisors and had not attempted to coordinate any staff member to accompany Resident #3 to her appointment because she decided that no staff member was available to accompany Resident #3 to her appointment. LVN F stated, I decided we did not have staff to send with her. I knew CNA C was already going to an appointment with another Resident.</p> <p>During an interview on 5/8/2025 at 3:53 PM the Medical Director stated he consulted with Resident #3's cardiologist and in their professional opinions the missed cardiology appointment on 11/13/2024 was for an echocardiogram and Resident would not have seen the physician. The MD stated the ideal would have been for Resident #3 to have had her images completed sooner rather than later but the delay did not impede her healthcare.</p> <p>During an interview on 5/9/2025 at 9:23 AM, the Administrator and the DON, stated the expectation was for all residents who had a need to attend a medical appointment were supported with their needs to attend their appointment. The DON stated she and her ADONs were not included in the decision to dismiss the ambulance service transportation for Resident #3 on 11/13/2024 and if they had been given a report the facility would have made attempts to chaperone Resident #3 to her appointment. The DON stated the risk to residents missing their appointments was varied and she could not speculate other than residents should be supported in attending their appointments.</p> <p>A record review of the facility's Prevention of Abuse, Neglect and Exploitation policy dated August 2024 revealed, The facility will implement policies and procedures to prevent and prohibit all types of . neglect, . that achieves: . Identifying, correcting and intervening in situations in which . neglect, . is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs</p>		