

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/30/2026
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)		
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct an initial comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity for one of 32 residents (Resident #45) reviewed for comprehensive assessments. The facility failed to complete and transmit an admission assessment for Resident #45 within 14 days of the resident's admission. This failure placed residents at risk of not having their needs, strengths, goals, life history and preferences assessed to ensure they received appropriate care. The findings included: Record review of Resident #45's electronic face sheet dated 01/28/2026 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including open wound on lower left leg, Type 2 diabetes with hyperglycemia (high blood sugar levels), bipolar disorder (a mental health condition that causes extreme mood swings) and morbid obesity (an excess of 80 to 100 pounds above ideal body weight). No previous admission date was indicated. Record review of Resident #45's electronic health record revealed an admission MDS assessment was initiated but the only section completed was Section F, Preferences for Routine & Activities. All the other sections were noted In Progress. The Complete By date for this assessment was 01/21/2026. Record review of a BIMS evaluation completed by the facility's speech therapist on 01/09/2026 revealed the resident scored 15/15, indicating intact cognition. Record review of the resident's EHR revealed the facility initiated a comprehensive care plan for Resident #45 on 01/09/2026 that included the resident's code status, medications, cognitive function, self-care deficits, pain, and activity preferences. During an interview on 01/28/2026 at 10:30 AM, MDS LVN A stated she was responsible for completing the admission MDS for Resident #45, it was due on 01/21/2026, and she failed to complete the admission MDS in a timely manner. MDS LVN A stated she would have to check her schedule to see what other duties she was assigned the day it was due, and with her supervisor to verify why it was not completed in a timely manner. During an interview on 01/28/2026 at 10:55 AM, the administrator stated the facility had two MDS LVNs who were responsible for completing MDS assessments but they were occasionally assigned other duties. The administrator stated it was important MDS assessments were completed in a timely manner so the facility knew how to care for the residents. During an interview on 01/28/2026 at 11:05 AM, the DON stated the MDS LVN was responsible for completing MDS assessments, but the facility's census had increased recently and it was difficult for the two MDS LVNs on staff to keep up with the assessments in a timely manner. The facility had placed advertisements to hire another full-time employee and prn MDS LVN to help keep up with the workload. The DON said completing assessments in a timely manner was important so the facility was familiar with the residents' needs and were able to formulate comprehensive care plans. Record review of the facility's policy Resident Assessment and Associated Processes revised 12/2023 revealed, Policy: It is the policy of this facility that residents will be assessed and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessment of each resident and will be conducted initially and periodically as part of an ongoing process through which each resident's preferences and goals of care, functional and health (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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	status, and strengths and needs will be identified. Procedure: Comprehensive MDS assessment include Admission, Annual, significant Change in Status Assessment and Significant Correction Prior to Comprehensive Assessment. 3. Comprehensive assessments will be conducted within 14 days of admission .Record review of CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1 October 2025, 2.6 Required OBRA Assessments for the MDS, Comprehensive Assessments, 01. admission Assessment, revealed, The admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the day of admission to the nursing home as day 1, if: this is the resident's first time in this facility, ORthe resident has been admitted to this facility and was discharged return not anticipated, ORthe resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure an encoded, accurate and complete discharge MDS was electronically completed and transmitted to the CMS System within 14 days after completion for 1 of 4 residents (Resident #20) reviewed for discharge MDS assessments. The facility failed to ensure a discharge MDS was completed and transmitted for Resident #20's within 14 days of his discharge to the hospital. This failure could place residents at risk of not having assessments completed and submitted in a timely manner as required. The findings included: Record review of Resident #20's electronic face sheet, accessed on 01/27/2026, revealed the resident was a [AGE] year-old male admitted on [DATE] with diagnoses that included epilepsy (seizures), Type II diabetes (a problem in the way the body regulates and uses blood sugar), acute respiratory failure (a life-threatening condition that occurs when fluid leaks from small blood vessels in the lungs and builds up in the air sacs) and cerebral infarction due to occlusion of left middle cerebral artery (stroke that may result in paralysis on one side of the face or body or loss of coordination). The resident's payer source was Medicare A. Record review of Resident #20's EHR revealed a progress note by LVN B dated 01/07/2026 at 5:40 PM stating the resident experienced a sudden loss of consciousness in the dining room with hypotension (a decrease in blood pressure) and agonal breathing (involuntary respirations caused by low oxygen in the blood). The resident's MD was notified immediately, who gave the order to send the resident to the ER. Emergency services were notified, arrived at 5:52 PM, and transported the resident to the hospital. Record review of Resident #20's EHR revealed a progress note by NP D dated 01/09/2026 at 8:00 PM stating she was unable to round with the resident due to his transfer to the hospital for loss of consciousness and an increase in oxygen demand. Record review of Resident #20's electronic MDS assessments revealed an admission MDS Assessment with an ARD of 11/01/2025. There was no evidence of a discharge MDS completed or transmitted to CMS. During an interview on 01/27/2026 at 2:30 PM, MDS LVN A stated when residents were discharged to the hospital they were generally anticipated to return to the facility, and Resident #20's discharge MDS should have been initiated the day the resident left or the day after. It was her responsibility to complete and transmit the discharge MDS and she missed it. She was occasionally assigned other duties besides the completion of MDS assessments and could not explain specifically why this discharge MDS was missed, but understood timely completion of discharge assessments was important. During an interview on 01/28/2026 at 10:55 AM, the administrator stated the facility had two MDS LVNs who were responsible for completing MDS assessments but they were occasionally assigned other duties. The administrator stated it was important MDS assessments were completed in a timely manner so the facility knew how to care for the residents. During an interview on 01/28/2026 at 11:05 AM, the DON stated the MDS LVN was responsible for completing MDS assessments, but the facility's census had increased recently and it was difficult for the two MDS LVNs on staff to keep up with the assessments in a timely manner. The facility had placed advertisements to hire another full-time employee and prn MDS LVN to help keep up with the workload. The DON said completing assessments in a timely manner was important so the facility was familiar with resident needs and were able to formulate comprehensive care plans. Record review of CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1 October 2025, 2.5 Assessment Types and Definitions, revealed, Discharge refers to the date a resident leaves the facility or the date the resident's Medicare Part A stay ends but the resident remains in the facility. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether discharge occurs at 12:00 a.m. or 11:59 p.m., this date is considered the actual date of discharge. There are three types of discharges: two are OBRA required-return anticipated and return not anticipated; the third is Medicare required-Part A PPS Discharge. A Discharge assessment is required (continued on next page)		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with all three types of discharges. Discharge Assessment refers to an assessment required on resident discharge from the facility, or when a resident's Medicare Part A stay ends, but the resident remains in the facility (unless it is an instance of an interrupted stay, as defined below). This assessment includes clinical items for quality monitoring as well as discharge tracking information. OBRA Discharge assessments consist of discharge return anticipated and discharge return not anticipated. [.] Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days).		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for one resident (Resident #53) reviewed for range of motion. The facility failed to ensure Resident #53's right hand splint (medical device used to treat hand contractures, permanent tightening of the muscles, tendons, skin and surrounding tissues that causes stiffness, placed in the hands to help improve range of motion) was in place to her right hand. This failure could place the resident at risk for decrease in mobility and range of motion and contribute to worsening of contractures. Record review of Resident #53's Face Sheet dated 01/29/26, documented a [AGE] year-old female originally admitted to the facility on [DATE] with her last admission date of 07/30/25. Resident #53's diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (neurological conditions causing one-sided body impairment, from a stroke), aphasia following cerebral infarction (language disorder resulting from damage to brain regions responsible for language comprehension and formulation, often following a stroke), dysphagia following cerebral infarction (difficulty swallowing after a stroke) and frontal lobe and executive function deficit following cerebral infarction (a stroke that causes executive function deficits, affecting planning, decision-making, problem-solving, and impulse control leading to difficulty with daily tasks). Record review of Resident #53's Annual MDS dated [DATE] revealed a severe cognitive impairment for daily decision making. Section O - Special Treatments, Procedures and Programs did not indicate any therapy, including restorative nursing, in the last 7 days. Record review of Resident #53's Care Plan with the last revision date of 12/18/25 indicated a focus of Alteration in musculoskeletal status r/t impaired ROM to R hand. The intervention included FYI: Resident has a right-hand splint per restorative and or therapy. Monitor Right hand every shift for any s/sx of breakdown, redness, open areas, blistering, bruising, unusual skin appearance, every shift. The date initiated was 12/18/25. Record review of Resident #53's active orders as of 01/29/26 revealed an order dated 12/18/25 that stated FYI: Resident has a right hand splint per restorative and or therapy. Monitor Right hand every shift for any s/sx of breakdown, redness, open areas, blistering, bruising, unusual skin appearance, every shift. During an interview and observation with a family member on 01/29/26 at 1:40 pm, she said the splint on Resident #53's hand was paused when therapy stopped a few months ago. Resident #53 was observed with a rubber hand spacer with fingers in holes of a rubber device on her left hand but her right hand appeared to be curled under her shirt hem. During an interview on 01/29/26 at 1:53 pm with PT C who worked with Resident #53 stated the resident was discharged from PT and OT on 11/11/25 due to reaching her potential. PT C stated the Restorative Aide should have taken over the splint and nursing and therapy should have monitored it since there was an order to have it monitored. During an interview with RA E on 01/29/26 at 2:02 pm, RA E stated, We are doing lower extremities on Resident #53 like stretching her legs. We don't have program set up to do hand therapy. We see her 3 times per week. During an interview with the DON on 01/29/26 at 3:59 pm, the DON stated therapy was managing Resident #53's PT, OT and SLP but they were supposed to roll a restorative plan over to the RA after the resident no longer qualified for skilled therapy. Resident #53 already had a contracture and it could worsen without further interventions. The Director of Rehabilitation was the one who was supposed to set up restorative plans. The MDS Nurse wrote the care plan based on a splint management meeting. The RA plan was never set up. The Director of Rehabilitation was no longer employed so nursing was monitoring therapy and RA plans until a new Director was hired. Record review of the Weekly LTC Clinical Review Policy dated November 2025 revealed the following:Procedures:3. IDT members will review clinical documentation (therapy documentation, nursing documentation, Care Plans, MDS, etc.) and (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discuss progress and/or barriers to goal achievement on regular intervals of at least once per claim month. Areas of review to assist the IDT in this process to support the need for skilled therapy interventions will include, but not be limited to:c. Discuss and review documentation of any patient who has a barrier to the treatment plan to determine next steps in patient care. For example:i. Any medical complications and/or other reasons for limited progress.ii. Nursing or other IDT services that are addressing the barriers relevant to the medical condition.iii. Determine what information needs to be shared with the IDT/nursing team such as transfer status, pain management, dietary changes, new orders, need for transition to RNA, etc. Update Care Plan and MDS accordingly.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the safe and sanitary storage of residents' food items in 1 of 5 residents' refrigerators reviewed. The personal refrigerator in the resident's room [ROOM NUMBER]A contained unlabeled, undated food items. This failure could place residents at risk of foodborne illness from consuming spoiled food. The findings were: Observations on 1/27/2026 at 9:35 a.m. revealed that the personal refrigerator in RM [ROOM NUMBER] A contained cooked beef and white pasta in an unlabeled, undated storage container. Further observations on 1/27/2026 at 11:30 a.m. of the personal refrigerator in RM [ROOM NUMBER] A revealed that the cooked beef and white pasta in an unlabeled, undated storage container were still present. An interview with Resident # 104 on 01/27/2026 at 9:40 a.m. revealed that she could not recall how long the cooked beef and white pasta had been in her personal refrigerator, but recalls that her daughter, who visits often, leaves food in her personal refrigerator to eat when she visits. Interview on 01/27/2026 at 9:50 a.m., with CNA E stated she was assigned to Resident #104 and confirmed that the personal refrigerator in Resident #104's room contained cooked beef and white pasta, which were undated and unlabeled. She did not know who was responsible for checking the president's personal refrigerator for expired food, but would check with the charge nurse. Interview with LVN F on 1/27/2026 at 10:00 a.m. revealed she was the assigned nurse for Resident # 104 and confirmed there was cooked beef and white pasta in an unlabeled and undated storage container in the personal refrigerator. She added that nursing was responsible for removing undated and unlabeled food items from residents' personal refrigerators. LVN F stated that resident # 104's family member at times, brings in food to consume for herself during her visit and leaves leftovers in resident # 104's personal refrigerator. Resident # 104 risked some form of food-borne illness by possibly consuming food that was unlabeled and undated. Phone interview with Residents #104's family member on 01/27/2025 at 11:24 a.m. She confirmed that she leaves leftover food in the family's personal refrigerator to eat when she visits. She recalls DON instructing her to notify the nursing staff when she leaves food in the personal refrigerator so it can be labeled and dated, but she forgets. During an interview with the DON on 01/28/26, at 1:37 p.m., the DON confirmed that perishable food and drinks in residents' personal refrigerators should be labeled and dated to prevent residents from consuming spoiled food. The DON stated that nursing was responsible for removing undated, unlabeled food items from residents' refrigerators daily, including assisting families in labeling and dating food items brought in. The DON stated that families sometimes bring food for residents without notifying the nursing staff. She said she would send a memo to all family members instructing them to notify the nursing staff when they bring food to residents and place it in their refrigerators. She added that her charge nurses were responsible for overseeing this task, and her ADONs would be monitoring at random. Record review of the facility policy, Residents Personal Food Storage, 11/2016, revised, 1/2022, revealed: Residents and individuals bringing in food from outside sources will be educated on safe food handling and storage techniques by designated facility staff a		