

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676308	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER San Gabriel Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4100 College Park Dr Round Rock, TX 78665	

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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676308	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER San Gabriel Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4100 College Park Dr Round Rock, TX 78665	
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents had the right to be free from physical abuse by staff for 1 of 3 (Resident #1) residents reviewed for abuse. The facility failed to ensure Resident #1 was not physically abused by CNA A after Resident#1 suffered pain and fear after incontinent care was provided roughly by CNA A, using a dry towel and a healing labial skin tear was identified on 06/03/25. CNA A provided incontinent care to Resident #1 again with a dry towel and Resident #1 told CNA A not to come into her room. CNA A continued to provide care to Resident #1 until the day before her discharge on [DATE]. The facility failed to implement protective measures as CNA A continued to provide care to Resident #1 until the day before her discharge on [DATE]. An Immediate Jeopardy (IJ) was identified on 09/11/25 at 6:52 PM and an IJ template was provided. While the IJ was removed on 09/12/25 at 7:00 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to the facility need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for abuse, neglect, and exploitation. Findings included: Review of Resident #1's face sheet, dated 09/11/25, reflected a [AGE] year-old female originally admitted to the facility on [DATE], readmitted on [DATE], and discharged on 06/17/25. Her diagnoses included sequelae of cerebral infarction (complications that occur after a stroke), sepsis (a response to an infection that can cause organ damages), diabetes (a disease that affects how the body uses glucose), depression, anxiety, and osteomyelitis of sacral region (an infection of the tailbone). Review of Resident #1's 5-day MDS assessment, dated 05/15/25, Section C (Cognitive Patterns) reflected a BIMS score of 15, reflecting intact cognition. Section GG (Functional Abilities) reflected she was dependent on staff for toileting hygiene. Section H (Bladder and Bowel) reflected she was incontinent of bowel and bladder. Section M (Skin Conditions) reflected the resident had no pressure injuries/ulcers and no venous or arterial ulcers present and that she received pressure ulcer/injury care. Review of Resident #1's comprehensive care plan, revised 05/18/25, reflected in part as follows: Problem: Resident #1 experiences bowel incontinence. Goal: Resident #1 will not exhibit skin breakdown, constipation/impaction, impaired social interaction, secondary to bowel incontinence. Approach: .Report signs of skin breakdown or perianal excoriation (skin issues around the anus) . Use appropriate incontinence management products to promote hygiene and dignity. Use skin barrier after incontinent episodes. The care plan did not address a skin tear on the labia. Review of Resident #1's active physician's orders as of 06/16/25, printed on 09/11/25, reflected: Apply zinc barrier cream or Triad paste(an ointment used to protect the skin and promote wound healing) to wound on right posterior thigh, cover with xeroform BID. The order was dated 04/09/25. The physician orders did not address any treatment for a skin tear on the labia. Review of Resident #1's progress notes from 03/21/25 through 06/17/25 reflected a note written 06/03/25 at 10:09 PM by LVN C, Skin assessment performed. No new skin injuries were observed. Old skin tear to right labia appears 90% healed. No more redness present. Can barely see where the skin tear was. Healing well. Continuing to put barrier cream on skin tear during brief changes. There was no other documentation of a labial skin tear in the progress notes. There was no documentation of Resident #1 complaining of rough treatment by a CNA. There was no documentation that a head-to-toe assessment was completed. Review of Resident #1's progress notes provided by the ADM, reflected a note written, 04/05/25 at 3:14 PM by LVN P, reflected in part, Resident has a small open area to the right gluteal cleft. A note written 04/16/25 at 9:55 PM by LVN Q, reflected in part, Resident #1 is incontinent of B/B, treatment apply to open area to perineum area, and open area to buttock[sic]. Review of the readmission Skin assessment dated [DATE], reflected in part, R arm PICC (a line used for administering long term medications into a vein) ecchymosis peri (bruises around) exit site, no s/s infection. Max assist ADL. Redness to groin, skin moist, res obese. Reactive when touched, states painful to move skin to examen [sic], starts to cry. Review of the Skilled Nurses note dated 05/21/25 and written by LVN C, the skin section of the assessment reflected none of the questions were answered, no comments were documented, and there was no documentation of a labial skin tear. Review of the Skilled Nurses note dated 05/31/25 and written by LVN E reflected, the daily wound treatments were not completed, no comments were documented, and there was no documentation of a labial skin tear. Review of the Skilled Nurses noted dated 06/08/25 and written by LVN E, reflected the daily wound treatments were not completed, no comments were documented, and there was no documentation of a labial skin tear. Review of the NP notes for Resident #1 dated 05/23/25</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676308	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER San Gabriel Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4100 College Park Dr Round Rock, TX 78665	

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 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676308	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER San Gabriel Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4100 College Park Dr Round Rock, TX 78665	
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 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure in response to allegations of abuse, neglect, exploitation, or mistreatment the facility had evidence that all alleged violations were thoroughly investigated and prevent further abuse, neglect, exploitation, or mistreatment while the investigation was in progress for 1 of 3 residents (Residents #1) reviewed for abuse and neglect. The facility failed to investigate and report abuse when Resident #1 suffered pain and fear after incontinent care was provided roughly by CNA A, using a dry towel and a healing labial tear was identified on 06/03/25. CNA continued to provide incontinent care to Resident #1 until the day before her discharge on [DATE]. An Immediate Jeopardy (IJ) was identified on 09/11/25 at 6:52 PM and an IJ template was provided. While the IJ was removed on 09/12/25 at 7:00 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to the facility need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for abuse, neglect, and exploitation. Findings included: Review of Resident #1's face sheet, dated 09/11/25, reflected a [AGE] year-old female originally admitted to the facility on [DATE], readmitted on [DATE], and discharged on 06/17/25. Her diagnoses included sequelae of cerebral infarction (complications that occur after a stroke), sepsis (a response to an infection that can cause organ damages), diabetes (a disease that affects how the body uses glucose), depression, anxiety, and osteomyelitis of sacral region (an infection of the tailbone). Review of Resident #1's 5-day MDS assessment, dated 05/15/25, Section C (Cognitive Patterns) reflected a BIMS score of 15, reflecting intact cognition. Section GG (Functional Abilities) reflected she was dependent on staff for toileting hygiene. Section H (Bladder and Bowel) reflected she was incontinent of bowel and bladder. Section M (Skin Conditions) reflected the resident had no pressure injuries/ulcers and no venous or arterial ulcers present and that she received pressure ulcer/injury care. Review of Resident #1's comprehensive care plan, revised 05/18/25, reflected in part: Problem: Resident #1 experiences bowel incontinence. Goal: Resident #1 will not exhibit skin breakdown, constipation/impaction, impaired social interaction, secondary to bowel incontinence. Approach: Report signs of skin breakdown or perianal excoriation (skin issues around the anus). Use appropriate incontinence management products to promote hygiene and dignity. Use skin barrier after incontinent episodes. The care plan did not address a skin tear on the labia. Review of Resident #1's active physician's orders as of 06/16/25, printed on 09/11/25, reflected: Apply zinc barrier cream or Triad paste (an ointment used to protect the skin and promote wound healing) to wound on right posterior thigh, cover with xeroform BID. The order was dated 04/09/25. The physician orders did not address any treatment for a skin tear on the labia. Review of Resident #1's progress notes from 03/21/25 through 06/17/25 reflected a note written 06/03/25 at 10:09 PM by LVN C, Skin assessment performed. No new skin injuries were observed. Old skin tear to right labia appears 90% healed. No more redness present. Can barely see where the skin tear was. Healing well. Continuing to put barrier cream on skin tear during brief changes. There was no other documentation of a labial skin tear in the progress notes. There was no documentation of Resident #1 complaining of rough treatment by a CNA. There was no documentation that a head-to-toe assessment was completed around the time of the allegation. Review of Resident #1's progress notes provided by the ADM, reflected a note written, 04/05/25 at 3:14 PM by LVN P, reflected in part, Resident has a small open area to the right gluteal cleft. A note written 04/16/25 at 9:55 PM by LVN Q, reflected in part, Resident #1 was incontinent of B/B, treatment apply to open area to perineum area, and open area to buttock[sic]. Review of the readmission Skin assessment dated [DATE], reflected in part, R arm PICC (a line used for administering long term medications into a vein) ecchymosis peri (bruises around) exit site, no s/s infection. Max assist ADL. Redness to groin, skin moist, res obese. Reactive when touched, states painful to move skin to examen [sic], starts to cry. Review of the Skilled Nurses note dated 05/21/25 and written by LVN C, the skin section of the assessment reflected none of the questions were answered, no comments were documented, and there was no documentation of a labial skin tear. Review of the Skilled Nurses note dated 05/31/25 and written by LVN E reflected, the daily wound treatments were not completed, no comments were documented, and there was no documentation of a labial skin tear. Review of the Skilled Nurses note dated 06/08/25 and written by LVN E, reflected the daily wound treatments were not completed, no comments were documented, and there was no documentation of a labial skin tear. Review of the NP notes for Resident #1 dated 05/23/25, 06/02/25, and</p>		