STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676308	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Gabriel Rehabilitation and Care Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free from abuse for 3 of 8 residents (R #3, R #4 and R #5) reviewed for abuse. The facility failed to ensure R#1did not hit R# 3 on the chest 3 times at the lunch table in the dining room for an unknown reason on 04/15/2026. The facility failed to ensure on 4/26/2026 at 10:30 am, R # 4 and R#1 did not get into an altercation when R#4 accidently bumped his wheelchair into R#1s wheelchair by the nurse's station. The facility failed to ensure Resident #1 did not hit R# 5 when R# 5 was would not allow R# 1 to play dominoes on 04/26/2026 at 2:15 pm. This failure could place residents at risk of abuse, physical harm, mental anguish and/or emotional distress. Record review of R #1 s face sheet, dated 04/30/26, reflected R #1 was a [AGE] year-old female, readmitted to the facility on [DATE], diagnoses included Epilepsy (A neurological disorder that causes seizures or unusual sensations and behaviors.) (Schizoaffective Disorder, bipolar type (condition that causes extreme mood swings that include emotional highs, also known as mania, (a state of abnormally elevated mood)or hypomania,and lows, also known as depression. Hypomania is less extreme than mania) and Hypertension (High blood pressure). Record review of the quarterly MDS assessment, dated 02/04/26, reflected R#1 Bim's score was 8 indicating she was moderately impaired. The MDS indicated R#1 required Supervision with ALDs such as toileting hygiene. Record review of R #1's comprehensive care plan revised 02/17/26, reflects her mood and behavior needs evidenced by rejection of care, verbal, and physical behaviors directed towards others. The care plan interventions included Administer medications as ordered. Monitor and record effectiveness. Report any adverse side effects, assess whether the behavior endangers the resident and/or others. Intervene if necessary. Offer activities of interest such as coloring, word search, drawing, singing & knitting.Record review of R#1's progress notes reflected on 4/18/26 at 7:58 a.m., R#1 was observed by staff trying to leave the facility. On 04/18/26 at 11 a.m., R#1 was seen pulling hair of RECPT and punching her in the face two times. R#1 was reoriented by RECPT. The DON instructed the Charge Nurse to have resident sent to ER for psych evaluation. The NP was notified and agreed with the DON. EMT arrived to take R#1 to hospital. R#1 returned to the facility on [DATE] at 1:59 p.m. CNA was instructed to sit with R#1 until further notice. On call NP instructed that she would call the on-call physician for further instructions. New orders to call police to get protective custody hold on resident for psychological treatment. Police assessed resident conclusion was R#1 was not an immediate threat or danger in this moment. Psychiatrist ordered 1time intermuscular injection of Zyprexa 10 mg and a 1time order of Ativan 1mg 2 hours later.Progress notes 4/26/26 at 10:58 a.m., the DON was notified by phone call of R#1's previous behavior and the DON instructed RN B to call 911 crisis officers to respond and assess R#1. Fifteen-minute safety checks were put in place per protocol. RP was notified of R#'s behavior. Attempt made to contact psychological NP for further evaluation: awaiting response. At on or about 11:30 a.m., Crisis officers arrived to assess R#1. During their presence, R#1 was observed striking R# 5 three times on the right arm. Crisis officers and Nursing staff intervened immediately and de-escalated the situation. R#1 Record review of R #3's face sheet, reflected R #3 was an [AGE] (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	year-old female, admitted to the facility on [DATE] with primary diagnoses Chronic obstructive pulmonary disease, (Is a common, preventable and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough), Unspecified dementia(A group of symptoms that affects memory, thinking and interferes with daily life.) and anxiety (feeling of uneasiness or worry). Record review of R #3's annual MDS, dated [DATE], reflected R#3's BIMS score was 15, which indicated her cognition was intact. The MDS reflected R #3 had no behavioral issues and she needed set up or clean-up assistance with regards to ADLs. Record review of R #3's comprehensive care plan initiated on 04/02/26 reflected R #3 had mood, and behavior needs were evidenced by withdrawn tendencies related to DX depression. The goal for R#3 was to discuss feelings that may lead to feeling down, depressed or hopeless over the next 90 days. Interventions included staff acknowledgement to the R#3 that the current situation must have been difficult and administer medications as ordered. Monitor and record effectiveness. Report adverse side effects. Record review of R #4's face sheet, reflected R #4 was an [AGE] year-old male, readmitted to the facility on [DATE] with primary diagnoses Parkinsonism (A progressive disorder that affects the nervous system and the parts of the body controlled by the nerves.), Lewy bodies (cognitive changes or hallucinations) and Type 2 diabetes (is a chronic condition characterized by insulin resistance and high blood sugar levels.). Record review of R #4's annual MDS, dated [DATE], reflected R #4's BIMS score was 13 indicating his cognition was intact. The MDS reflected R #3 needed set up or clean-up assistance with regards to some ADLs and he needs substantial / maximal assistance with toileting and bathing. Record review of R #4's comprehensive care plan initiated on 04/17/26 reflected R #4 refused assistance with eating though he is struggled to assist himself. R #4 has been educated on weight loss. R #4?s goal was, he was to have 0- minimal adverse side effects related to refusal. Interventions included allowing R# 4 to have control over situations, if possible, convey an attitude of acceptance toward the R# 4 and maintain a calm environment and approach to the R#4. Record review of R #5's face sheet, reflected R #5 was an [AGE] year-old female, readmitted to the facility on [DATE] diagnoses included Cerebral infarction, (the pathologic process that results in an area of necrotic tissue in the brain. It is caused by disrupted blood supply (ischemia) and restricted oxygen supply (hypoxia).)Diabetes mellitus Type 2, (A condition results from insufficient production of insulin, causing high blood sugar.) Morbid (severe) obesity (is a severe chronic condition characterized by a body mass index (BMI) of 40 or higher, significantly increasing the risk of serious health complications.). Record review of R #5's annual MDS, dated [DATE], reflected R #5's BIMS score was 12 reflecting she had moderate problems with thinking and memory. The MDS reflected R #5 needed set up or clean-up assistance with regards to some ADLs and she needs substantial / maximal assistance with toileting and bathing. Record review of R #5's comprehensive care plan initiated on 04/20/26 reflected R #5 tends to refuse showers and wanted to take a shower once a week. The goal was she will be clean, dressed appropriately for weather, participate to preferred activities, and stable weight for 90 days. Interventions include continue to provide and offer shower per shower schedule, administer medications as prescribed and encouraging R#5 to perform self-care to the maximum ability. During an observation and interview on 04/30/26 at 10:05 a.m., revealed R #3 was sitting in her wheelchair in the TV room reaching for reading materials on the shelf. R #3 stated she was struck on the chest 3 times by R #1. She stated, I don't know why she hit me on the chest, I was not doing anything to her. R#3 stated she was not injured and that she was not afraid of R#1. During an observation and interview on 04/30/26 at 10:22 a.m., revealed R #4 was sitting in his wheelchair and playing cards by himself. Resident #4 stated he recalled the incident when R#1 stuck him in the face. R#4 stated, he accidently bumped his wheelchair into R#1's wheelchair while he was moving past the nurse's station. R#4 stated, she took a swipe at me, she's crazy. R#4 stated, I hit her back. He stated, I'm not afraid of R#1 During an observation and interview on 04/30/26 at 1:44 p.m., revealed R# 5 was sitting in her room watching TV. R# 5 recalled, on Sunday 4/26/26 at 2:15 p.m., she was in the dining room with 2 other residents. She stated, We were playing dominoes. She said (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R#1 asked to play with them. R#5 stated she would not allow R#1 to play because the last time she played, she didn't get it and she was unable to complete the game. R#5 said, R# 1 hit her 3 times on her right arm. R#5 stated, I was not hurt. R# 5 stated she is not afraid of R#1. During an interview on 04/30/26 at 1:53 p.m., it was revealed that R# 6 witnessed an incident on 04/26/26 at around 2 p.m. in the dining room. R#6 stated, she was playing dominoes with R# 5 when she saw R#1 start hitting R#5's right arm. R# 6 stated she doesn't know what happened to R#1 and that she is not afraid of R#1. R# 6 stated, I don't' think she should be allowed to come back to this facility.During an interview on 05/01/26 at 12:29 p.m., R#1's RP stated she understands that her mother has psychological issues but she believes the facility can meet R#1's needs. RP said R#1 likes this facility. RP stated she has talked with her mother about R#1s tendency to hit other residents. RP stated she told R#1 that it is not ok for her to hit other residents. During an interview on 05/01/26 at 1:52 p.m., MD stated he had been informed of the R#1's behaviors and ongoing progress. The MD stated R#1 has not been injured during any of the abuse incidents reported in April of 2026. The MD stated he believed the facility could ensure the safety of the residents at this facility if they are able to confirm R#1's medications are effective and when the resident returns, and the facility does frequent monitoring of R#1's behaviors. During an interview on 04/30/26 at 11:05 a.m., CNA A stated she responded to shouting coming from the dining room on 04/15/26 at around 12 noon. CNA A stated that she observed R #3 sitting at the table and R#3 was crying. She stated, I separated R#1 and R# 3. She stated, R # 3 told her that R#1 hit her 3 times on the chest. CNA A said, R# 8 said that R#1 had struck R # 3. CNA A reported she has worked for this facility for 3 years and she has received training in Abuse, Neglect and Exploitation as well as on resident rights. During an interview on 4/30/26 at 3:15 p.m., RN B stated she observed R # 1 sitting at the nursing station on 4/26/26 at around 12:30 p.m. RN B stated she was at the nursing station charting and when she heard shouting. RN B stated she observed R# 4 and R#1's wheelchairs were locked together and both R #1 and R #4 were striking each other. RN B stated she separated the Residents. RN B stated she reported the incident. RN B stated she has been trained on Abuse, Neglect and Exploitation and Resident Rights. During an interview on 04/30/26 at 4:34 p.m., R #6 stated that on 4/26/26 at around 2 p.m., she witnessed R#1 grab R# 5's arm. R# 6 said R#1 started getting angry when she doesn't get what she wants. During an interview on 04/30/26 at 10:25 a.m., the DON stated on 04/15/26 around noon, she was coming out of the supply closet when she was informed that R#1 struck another resident. The DON stated, I've never known R#1 to act out and strike another resident before. The DON stated both residents were assessed head to toe and no injuries were noted. She stated that the Medical Director was notified of the incident. The DON stated the following day 04/16/26, orders were received to increase R#1s Geodon dosage from 40 - 60 mg. On 04/16/26 R#1's care plan was updated to reflect R#1 has history of verbal and physical behaviors directed towards others. The DON stated on 04/16/26 at 1:47 p.m., R#1 was observed trying to open front door however, she was unsuccessful and then the staff redirected R#1. The DON stated R#1 was put on 15-minute observations for 72 hours. The DON stated she believed the facility put interventions into place however, these interventions did not stop R#1 from hitting other Residents. The DON stated she has been trained on Resident rights and on Abuse, Neglect and Exploitation. She stated both she and ADON are responsible for in-servicing staff on ANE and RRs and they have had training recently, within the last month. During an interview on 4/30/26 at 4:45 p.m., ADM said, the facility can ensure the safety of all residents by engaging interventions such as the use of Medical Providers, medications and activities and socialization for each resident., The ADM stated, if we cannot meet the needs of a resident, we will find an alternative facility that is able to meet their needs. Record review of the facility's policy titled Leadership Policies and Procedures Abuse/Neglect revised 11/01/17 reflected: POLICY:1. The facility's Leadership prohibits neglect, mental, physical and/or verbal abuse, use of a physical and/or chemical restraint not required to treat a medical condition, involuntary seclusion, corporal punishment and misappropriation of a patient's/resident's property and/or funds and ensures that alleged violations involving abuse, neglect, exploitation or (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mistreatment, including injuries of unknown source and misappropriation of resident property, and are reported immediately.4. The facility's Leadership will provide notification to the proper authorities, and, when required, the release of information to those agencies, pursuant to applicable federal and/or state law. DEFINTIONS as defined by CMS section 483.5:1. Abuse. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.2. Adverse event. An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof. Component II: Training1. All new and current employees, including volunteers, receive continuous education, training and reinforcement that identify all aspects of abuse prohibition, to include:A. The prompt reporting of allegations without fear of reprisal. Abuse Prohibition Handout which includes information on how to and to whom concerns are reported without fear of retribution (located in the Abuse Prohibition binder) 4. Adequate supervision of staff is maintained to identify and prevent inappropriate behaviors, such as: 5. Ongoing assessment, care planning, and monitoring of those patients/residents with special needs that may lead to neglect, for example:A. History of aggressive behavior.B. History of entering other patient rooms. SECTION III: ORGANIZATIONAL ETHICSComponent V: Reporting/Response2. An analysis is completed to determine what changes are needed, if appropriate, to prevent further occurrences. Component VI: InvestigationThe facility maintains that all allegations of abuse, neglect, misappropriation of property, etc. are thoroughly investigated and appropriate actions are taken. If the alleged abuse or neglect involves serious physical harm to the patient/resident, please contact the facilities Clinical Services Director and/or Regional [NAME] President of Operations. You may be directed to contact the facilities Legal Department (Legal Department). The Legal Department will determine whether to direct an investigation (i.e., privilege an investigation) so as to protect the results of such investigation from third-party discovery. In the event another patient/resident, a family member or visitor, etc. is accused of abuse/neglect against a patient/resident, the facility will intervene and take appropriate steps to safeguard the patient/resident during and after the investigation. Component VII: Protection1. During the investigation, the facility protects the patient/resident, as appropriate, including but not limited to the following:A. Removal of the alleged abuser from the patient/resident care setting.B. Enforcing a Zero Tolerance standard for retaliation against the alleged victim.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 3 of 6 residents (Resident #1, Resident#2 and Resident #3) reviewed for respiratory care.The facility failed to ensure the nebulizer masks and tubing of Resident #1, Resident #2 and Resident #3 were stored safely in protective bags.This failure placed residents at risk for respiratory infections through contamination.Findings included:Record review of Resident #1's face sheet, dated 04/30/26, reflected Resident #1 was admitted to the facility on [DATE]. Resident #1 was an [AGE] year-old female, diagnoses included acute and chronic respiratory failure (difficulty to breath) , muscle weakness, shortness of breath, need for assistance with personal care, type 2 diabetes mellitus and dementia.Record review of Resident #1's initial MDS dated [DATE] revealed the BIMS assessment was not completed.Record review of Resident #1's baseline care plan dated 04/24/26 reflected that Resident's immediate health and safety needs will be identified.Record review of Resident #1's physician's order reflected: Ipratropium-albuterol solution for nebulization; 0.5 mg-3mg (2.5 mg base)/3 ml.Amount to Administer: 1; inhalation. -Start Date-04/23/2026Record review of Resident #2's face sheet, dated 04/30/26, reflected Resident #2 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 was an [AGE] year-old female diagnosed withCOPD, cardiac arrest, tension-type headache, nausea with vomiting, need for assistance with personal care, obstructive sleep apnea (breathing difficulty while sleeping) , chronic pain, end stage renal disease (kidney disease) , type 2 diabetes mellitus, syncope (fainting) and collapse.Record review of Resident #2's annual MDS dated [DATE] reflected a BIMS score of 15 indicating her cognition was intact. The MDS indicated she was on oxygen therapy for respiratory issues.Record review of Resident #2's care plan dated 04/02/25 reflected that she had COPD and relevant intervention was administering aerosol or bronchodilators as ordered and monitoring and documenting any side effects and effectiveness.Record review of Resident #2's physician's order reflected: EQUIPMENT: Keep O2 cannula/mask/tubing and/or Nebulizer mask/tubing bagged when not in use. -Start Date: 04/08/2024Record review of Resident #3's face sheet, dated 04/30/26, reflected Resident #3 was admitted to the facility on [DATE]. Resident #3 was an [AGE] year-old female, diagnoses included chronic obstructive pulmonary disease (difficulty to breath), hypertension, dementia, moderate, asthma, chronic pain, dizziness and giddiness, shortness of breath and chronic respiratory failure.Record review of Resident #3's annual MDS dated [DATE] reflected a BIMS score of 12 indicating her cognition was moderately impaired. Further review revealed that one of her active diagnoses was respiratory failure.Record review of Resident #3's care plan dated 02/20/26 reflected that she was at risk for respiratory distress/SOB due to asthma and COPD. Intervention included administering breathing treatments as ordered and keeping Nebulizer mask/tubing bagged when not in use.Record review of Resident #3's physician's order reflected: budesonide suspension for nebulization; 0.5 mg/2 mL; Amount to Administer: 1 INH; inhalation. Twice a Day -Start Date-02/11/26.During an observation conducted on 04/30/26 starting at 12:30 PM in the rooms in different halls , of Resident #1, Resident #2, and Resident #3, it was observed that the tubes and masks of the nebulizers for all three residents were laid openly on the tables, not stored in protective bags, thereby exposing them to the open atmosphere.During an interview with Resident #1 at 12:30 PM on 04/30/26, she stated that staff administer medication via nebulizer. She stated she received her nebulizer treatment in the morning, and it was administered by the nurse. Resident #1 stated the nurses were totally handling the nebulizer and treatment and the morning nurse was helpful in providing her medication via nebulizer.During an interview with Resident #3 at 1:00 PM on 04/30/26, she stated that she received medication via nebulizer in the morning for her breathing issues that was (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered by the nurse. She stated she could not recall whether she removed the mask herself or if the nurse did. Resident #3 stated that the nurses at the facility were helpful and that she received all her medications on time. On 04/30/26 at 12:45pm,1:30pm and 2:00pm Resident #2 was not available for an interview as she was out of the facility with an appointment.During an interview on 04/30/26 at 1:40 PM, RN A stated she was the nurse responsible for Resident #1 and was tasked with bagging the mask and tubes in a protective cover. She stated if the equipment was not protected from external environmental factors, there was a risk of cross-contamination and microorganism colonization, which could lead to serious respiratory and other infections. RN A stated as the charge nurse on that day, she should have identified this noncompliance and corrected it immediately.During an interview on 04/30/26 at 1:50 PM, LVN B stated she was the charge nurse for Resident #2 and Resident #3. She stated she usually stores the nebulizer masks immediately after medication administration. She stated she was unsure about what happened on this day and that the residents or their family members might have taken the masks out of the packet. LVN B stated she was ultimately responsible for ensuring they were stored safely in a bag. She stated that sanitizing and protecting the masks and tubes help to limit the spread of respiratory diseases through contamination.In an interview conducted on 04/30/26 at 3:30 PM, the DON stated that nebulizer masks, tubing, and oxygen nasal cannulas should be cleaned and stored in a clean protective bag after use. She stated the practice was intended to minimize the risk of respiratory infections caused by contaminated equipment. The DON stated it was the nurses' responsibility to ensure this process was completed after medication administration. She stated it was important for nurses to conduct regular rounds to verify the proper storage of respiratory devices. Record review of the in-service since [DATE] revealed there were no in services on safe handling of respiratory equipment.Review of the facility policy Respiratory treatment, care and services program revised on 05/05/26 reflected: The Facility ensures the safe, appropriate and effective provision of respiratory treatment, care and services in accordance with professional standards of practice, the resident's plan of care and personal choice. Respiratory Equipment Maintenance: Maintenance of all respiratory equipment is in accordance with manufacturer specifications and consistent with federal, state, and local laws and regulations.Infection control practices including standard and transmission-based precautions are followed during:A. Provision of respiratory care, treatment, and services.B. Handling of equipment, including cleaning, storage, and disposal of regular and biohazardous waste.