

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2026
NAME OF PROVIDER OR SUPPLIER Hunters Pond Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 9903 Hunters Pond San Antonio, TX 78224	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program, designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for 13 of 13 residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13) reviewed for reporting requirements for infection control. The DON and Administrator failed to report to the state survey agency when Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13 tested positive for the influenza virus from 01/26/2026 to 02/05/2026. This failure could put the residents at risk of neglect, illness, communicable diseases, respiratory distress, and harm. Findings included: Record review of Complaint Intake Investigation Worksheet #1067849, dated 02/06/2026, revealed it was alleged the facility had 12 residents diagnosed with the flu (influenza-a contagious respiratory illness caused by influenza viruses that infect the nose, throat and lungs, lasting 3 - 7 days; and spreads via respiratory droplets from coughs, sneezes, or touching contaminated surfaces; and there was no self-report of the outbreak from the facility to HHSC. Record review of TULIP on 02/06/2026 at 4:45 p.m. revealed there were no self-reported incidents regarding an active influenza outbreak in the facility. Record review of the facility's undated Symptomatic Testing log revealed 13 residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13) were tested for the influenza virus from 01/26/2026 to 02/05/2026 and they were all positive for the virus. Resident #1 had symptoms on 01/25/2026, was tested on [DATE], the results were positive for influenza, and she was placed on droplet isolation precautions (infection control measures used to prevent the spread of the virus which include wearing a surgical mask, gown, and eye protection). Further record review revealed Resident #6 and Resident #7 had symptoms on 01/26/2026, were tested on [DATE], the results were received on 01/28/2026, both positive for influenza, and placed on droplet isolation precautions. Resident #5 had symptoms on 01/29/2026, was tested on [DATE], the results were positive for influenza, and he was placed on droplet isolation precautions. Resident #8 had symptoms on 01/30/2026, was tested on [DATE], the results were positive for influenza, and he was placed on droplet isolation precautions. Resident #4 had symptoms on 01/31/2026, was tested on [DATE], the results were positive for influenza, and he was placed on droplet isolation precautions. Resident #9 had symptoms on 02/01/2026, was tested on [DATE], the results were positive for influenza, and he was placed on droplet isolation precautions. Resident #10 had symptoms on 02/02/2026, was tested on [DATE], the results were positive for influenza, and she was placed on droplet isolation precautions. Resident #11 had symptoms on 02/02/2026, was tested on [DATE], the results were positive for influenza, and she was placed on droplet isolation precautions. Resident #2 had symptoms on 02/03/2026, was tested on [DATE], the results were positive for influenza, and she was placed on droplet isolation precautions. Resident #3 had symptoms on 02/03/2026, was tested on [DATE], the results were positive for influenza, and she was placed on droplet isolation precautions. Resident #12 and</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676331
		If continuation sheet Page 1 of 8

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #13 had symptoms on 02/05/2026, and were tested on [DATE], the results were positive for influenza, and they were placed on droplet isolation precautions. 1. Record review of Resident #1's Face Sheet, dated 02/09/2026, revealed she was admitted on [DATE], readmitted on [DATE] with diagnoses that included paraplegia (partial paralysis or impairment of use of the lower body and legs), protein-calorie malnutrition (inadequate intake of protein and calories resulting in loss of muscle mass), heart disease, difficulty swallowing, diabetes (chronic elevated levels of sugar in the blood that can cause impairment of tissues), and dementia (cognitive impairment that can affect thought process). Record review of Resident #1's MDS, a quarterly assessment dated [DATE], revealed her cognitive skills for daily decision making were not impaired, and the resident was on isolation for an active infectious disease. Record review of Resident #1's care plan, dated on 10/02/2025, revealed the resident consented and received the influenza vaccine on 10/01/2025 and interventions were to monitor and report to the physician any signs or symptoms of influenza. Record review of Resident #1's care plan, initiated on 01/26/2026, revealed the resident had a respiratory infection (influenza A), and interventions included providing medications as ordered, monitoring of the resident's condition, and droplet-based precautions. Record review of Resident #1's Physician's Order Summary Report, dated 02/09/2026, revealed Geri-Tussin oral liquid 100 mg/5ml (a cough syrup) give 10 ml by mouth every 4 hours for cough times 7 days was ordered on 01/25/2026. Record review of Resident #1's Physician's Order Summary Report, dated 02/09/2026, revealed an order dated 01/25/2026 for Ipratropium-Albuterol Solution (Duoneb) 0.5-2.5 (3) mg/3 ml 1 vial inhale orally four times a day for congestion for 5 days. Record review of Resident #1's Physician's Order Summary Report, dated 02/09/2026, revealed a one-time order for a COVID/Flu A/B test was ordered on 01/26/2026. Record review of Resident #1's Physician's Order Summary Report, dated 02/09/2026, revealed an order on 01/26/2026 for droplet isolation precautions and an order for Isolation for Influenza A single bed occupancy was started on 01/26/2026. Record review of Resident #1's Physician's Order Summary Report, dated 02/09/2026, revealed an order on 01/26/2026 for Oseltamivir Phosphate (Tamiflu-an antiviral medication) oral capsule 75 mg 1 capsule twice a day for 5 days for influenza was started on 01/27/2026. Record review of Resident #1's electronic clinical record immunization section revealed she received the influenza vaccine on 10/01/2025. Record review of Resident #1's Rapid Influenza A test on 01/26/2026 revealed she was positive for Influenza A. Record review of Resident #1's Nurses Notes dated 01/25/2026 by LVN A revealed a Change of Condition was completed due to the resident having cough and congestion. The resident's nurse practitioner was notified who gave orders for geritussin (a cough syrup) 10 ml every 4 hours for 7 days, and DuoNeb (a prescribed inhalation medication administered via nebulizer [a device that converts liquid medication into a fine mist allowing the medication to be inhaled directly into the lungs] to open airways in the lungs). Record review of Resident #1's Nurses Notes dated 01/26/2026 at 10:28 a.m. by LVN B revealed Resident #1 was seen by the nurse practitioner for the resident's cough and congestion with new orders obtained for COVID/Flu A/B test. Record review of Resident #1's Nurses Notes dated 01/26/2026 at 11:26 a.m. by LVN B revealed Resident tested positive for Flu A. Resident has been placed on isolation, end date undetermined at this time. New order for Oseltamivir Phosphate 75 mg PO BID x 5 days. family notified of test results and isolation room change. Observation on 02/08/2026 at 12:48 p.m. revealed Resident #1 was no longer on isolation precautions and was in a room by herself. During an interview on 02/08/2026 at 12:48 p.m., Resident #1 stated when she was diagnosed with the flu, she was moved to the room she was currently in. 2. Record Review of Resident #6's Face Sheet, dated 02/09/2026, revealed she was admitted on [DATE] with diagnoses that included Schizophrenia (a chronic mental disorder with disrupted thoughts, emotions, and behaviors that can involve</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Report, dated 02/09/2026, revealed an order on 01/28/2026 for droplet isolation precautions started on 01/28/2026. Record review of Resident #7's Physician's Order Summary Report, dated 02/09/2026, revealed an order on 01/28/2026 for Tamiflu oral capsule 75 mg 1 capsule twice a day for 5 days for influenza was started on 01/28/2026. Record review of Resident #7's electronic clinical record immunization section revealed she received the influenza vaccine on 10/01/2025. Record review of Resident #7's Lab results for Rapid A/B influenza, dated 01/28/2026 revealed she was positive for influenza A. Record review of Resident #7's Nurses Notes dated 01/26/2026 by LVN C revealed a Change of Condition was completed due to the resident complained of cough and congestion. Resident #7's physician was notified, and orders were received to check for the flu and COVID. Record review of Resident #7's Nurses Notes dated 01/26/2026 by LVN C noted resident was hot to touch at beginning of shift, was given Tylenol, resident's temperature 2 hours later 98.7F, resident had flu swab done and sent to lab. Record review of Resident #7's Nurses Notes dated 01/27/2026 by RN D revealed the resident no longer had a fever or a cough during the shift, vitals were within normal limits, and the flu test result was pending. Record review of Resident #7's Nurses Notes dated 01/28/2026 at 06:07 a.m. by RN D revealed the nurse received a call from the lab that the resident tested positive for influenza A. Resident #7's physician's nurse practitioner was notified, and orders were received for Tamiflu 75 mg by mouth twice a day for 5 days. Resident #7 on isolation at this time. Record review of Resident #7's Nurses Notes dated 01/28/2026 at 06:43 a.m. by RN D revealed the resident was on single room isolation. Record review of Resident #7's Nurses Notes dated 01/28/2026 at 10:01 a.m. by RN E revealed Resident #7 [was] placed in single occupancy room for Influenza A, isolation as of 01/28/2026, all services to be rendered in room with proper PPE. 4. Record review of Resident #5's Face Sheet dated 02/09/2026, revealed he was admitted on [DATE] with diagnoses which included anemia (low iron stores in the body), protein-calorie malnutrition (inadequate intake of calories and protein resulting in depletion of muscle), diabetes (chronic elevated levels of sugar in the blood that can cause impairment of tissues), and cognitive communication deficit (difficulty communicating due to cognitive impairment) and was in a private room on the same hall where Resident #1, #6 and #7 resided. Record review of Resident #5's MDS, a quarterly assessment dated [DATE], revealed a BIMS score of 15 out of 15, his cognitive skills for daily decision making were not impaired, and the resident was on isolation for an active infectious disease. Record review of Resident #5's care plan, dated 10/30/2025 and revised on 07/20/2025, revealed he was at risk for influenza related to refusal of the vaccine; and under interventions were to monitor and report any signs or symptoms of influenza to the physician. Record review of Resident #5's care plan, initiated on 01/29/2026, revealed the resident received Tamiflu until 02/03/2026 for diagnoses of Influenza A. Interventions included droplet isolation precautions, administer medications as ordered, and monitor symptoms. Record review of Resident #5's Physician's Order Summary Report, dated 02/09/2026, revealed a one-time order for a flu antigen test was ordered on 01/29/2026. Record review of Resident #5's Physician's Order Summary Report, dated 02/09/2026, revealed an order on 01/29/2026 for droplet isolation precautions started on 01/29/2026. Record review of Resident #5's Physician's Order Summary Report, dated 02/09/2026, revealed an order on 01/29/2026 for Tamiflu oral capsule 75 mg 1 capsule twice a day for 5 days for influenza was started on 01/29/2026. Record review of Resident #5's electronic clinical record immunization section revealed he refused the influenza vaccine. Record review of Resident #5's Lab results for Rapid A/B influenza test, dated 01/29/2026 revealed he was positive for influenza A. Record review of Resident #5's Nurses Notes dated 01/29/2026 at 7:43 a.m. by RN F revealed a Change of Condition was completed due to the resident had a fever of 100.7F. Resident #7's nurse practitioner was notified, and orders were received to check</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>vaccine on 10/01/2025. Record review of Resident #9's Nurses Notes dated 02/01/2026 at 01:39 p.m. by LVN K revealed a Change of Condition was completed due to the resident fell and hit his head, had an elevated pulse of 105, elevated respiratory rate of 22 breaths per minute, and a normal temperature. The primary physician was notified, and an order was received to send him to the ER. Record review of Resident #9's Nurses Notes dated 02/01/2026 at 9:36 a.m. by RN I revealed Resident #9 returned from the hospital with a new order for Tamiflu 75 mg 1 capsule twice a day for 5 days. Record review of Resident #9's Nurses Notes dated 02/03/2026 at 1:36 p.m. by RN E revealed he was placed on droplet isolation precautions due to Influenza A, all services to be rendered in the room with proper PPE, the resident's RP was made aware. Record review of Resident #9's Hospital Patient Education & Visit Summary, dated 02/01/2026, revealed he was evaluated in the ER for a fall and was diagnosed with influenza A 8. Record review of Resident #10's Face sheet revealed she was admitted on [DATE], and readmitted on [DATE] with diagnoses that included Parkinson's disease (an incurable progressive degeneration of the central nervous system), high blood pressure, swallowing difficulty and dementia (cognitive impairment that can affect thought process); and resided in the same hall as Resident #4, #8, and #9. Record review of Resident #10's MDS, a quarterly assessment dated [DATE], revealed a BIMS score of 15 out of 15, no impairment with her cognitive skills for daily decision making, and the resident was on isolation for an active infectious disease. Record review of Resident #10's care plan, dated 10/04/2021 and revised on 10/02/2025, revealed the resident consented and received the influenza vaccine; and interventions to monitor and report any signs or symptoms of influenza to the physician. Record review of Resident #10's care plan, initiated on 02/02/2026, revealed the resident received Tamiflu until 02/07/2026 for diagnoses of Influenza A. Interventions included droplet isolation precautions, administer medications as ordered, and monitor symptoms. Record review of Resident #10's Physician's Order Summary Report, dated 02/09/2026, revealed a one-time order for a COVID/Flu A/B test was ordered on 02/02/2026. Record review of Resident #10's Physician's Order Summary Report, dated 02/09/2026, revealed an order on 02/02/2026 for droplet isolation precautions started on 02/02/2026. Record review of Resident #10's Physician's Order Summary Report, dated 02/09/2026, revealed an order on 02/02/2026 for Tamiflu oral capsule 75 mg 1 capsule twice a day for 5 days for influenza was started on 02/02/2026. Record review of Resident #10's electronic clinical record immunization section revealed she received the influenza vaccine on 10/01/2025. Record review of Resident #10's Lab results for Rapid A/B influenza, dated 02/02/2026 revealed she was positive for influenza A. Record review of Resident #10's Nurses Notes dated 02/02/2026 at 11:39 a.m. by the ADON revealed the resident had increased confusion, sitting in the hallway asleep and did not eat her breakfast. Resident #10's physician was notified, and orders were received to check for the flu and COVID. Rapid test was done with Resident #10 positive for Influenza A, her physician was notified. Record review of Resident #10's Nurses Notes dated 02/02/2026 at 12:12 p.m. by LVN G revealed the resident was moved for single room isolation. Record review of Resident #10's Nurses Notes dated 02/02/2026 at 12:17 p.m. by the ADON, revealed the resident's lab results were discussed with her physician, who started the resident on Tamiflu 75 mg BID for 5 days, the resident was moved to another room for single room isolation for droplet precautions, and her RP was notified and in agreement with the room change and treatment. Observation on 02/07/2026 at 4:27 p.m. revealed the door to Resident #10's room was shut, a droplet precaution sign was on the door, and a PPE cart was outside the room. 9. Record review of Resident #11's Face sheet revealed she was admitted on [DATE], and readmitted on [DATE] with diagnoses that included diabetes (chronic elevated levels of sugar in the blood that can cause impairment of tissues), high blood pressure, anemia (low levels of iron) and dementia (cognitive impairment that can affect</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2026
NAME OF PROVIDER OR SUPPLIER Hunters Pond Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 9903 Hunters Pond San Antonio, TX 78224	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>thought process); and resided in the same room as Resident #10. Record review of Resident #11's MDS, a quarterly assessment dated [DATE], revealed a BIMS score of 15 out of 15, no impairment with her cognitive skills for daily decision making, and the resident was isolated for an active infectious disease. Record review of Resident #11's care plan, dated 10/28/2024 and revised on 10/02/2025, revealed the resident consented and received the influenza vaccine; and under interventions were to monitor and report any signs or symptoms of influenza to the physician. Record review of Resident #11's care plan, initiated on 02/02/2026, revealed the resident received Tamiflu until 02/07/2026 for diagnoses of Influenza A. Interventions included droplet isolation precautions, administer medications as ordered, and monitor symptoms. Record review of Resident #11's Physician's Order Summary Report, dated 02/09/2026, revealed a one-time order for a COVID/Flu A/B test was ordered on 02/02/2026. Record review of Resident #11's Physician's Order Summary Report, dated 02/09/2026, revealed an order on 02/02/2026 for droplet isolation precautions started on 02/02/2026. Record review of Resident #11's Physician's Order Summary Report, dated 02/09/2026, revealed an order on 02/02/2026 for Tamiflu oral capsule 75 mg 1 capsule twice a day for 5 days for influenza was started on 02/02/2026. Record review of Resident #11's electronic clinical record immunization section revealed she received the influenza vaccine on 10/01/2025. Record review of Resident #11's Lab results for Rapid A/B influenza, dated 02/02/2026 revealed she was positive for influenza A. Record review of Resident #11's Nurses Notes dated 02/02/2026 at 6:36 p.m. by LVN L revealed a Change in Condition was reported due to Resident #11 had coughing, was weak, and had loose stools. The resident's physician was notified. Record review of Resident #11's Nurses Notes dated 02/02/2026 at 6:38 p.m. by the ADON, revealed the resident had nonproductive cough. Order was received for Rapid COVID and Flu A/B test to be done. Resident #11 was positive for Influenza A, her physician was notified, an order received for Tamiflu 75 mg BID for 5 days, and her RP was notified. Record review of Resident #11's Nurses Notes dated 02/02/2026 at 7:54 p.m. by the ADON, revealed the resident was placed on droplet isolation precautions; all services to be brought to the resident, and single room isolation was provided. Obs</p>		