

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676478	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2025
NAME OF PROVIDER OR SUPPLIER Harbor Valley Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 6211 Old Pearsall Road San Antonio, TX 78242	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observations, interviews and record reviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen. The facility failed to ensure [NAME] A wore a beard net on 11/12/25. This failure could place residents at risk of contaminated food and illness. Findings include: During an observation of the kitchen on 11/12/25 at 12:20 p. m., [NAME] A had facial hair and was not wearing a beard net and was checking food temperatures before lunch meal service. During an interview on 11/12/25 at 12:24 p.m., [NAME] A stated he was most recently reeducated on the beard net policy one year ago by the former DM. He stated all kitchen staff were responsible for following the facility's beard net policy. He stated he put on a beard net before checking food temperatures and preparing and serving meals. He also said, It was OSHA compliant to not wear a beard net if a beard was no more than 2 inches long. He stated he was still required to wear a beard net regardless of the facial hair length. He stated the DM oversaw and ensured kitchen staff wore beard nets. He stated he did not wear a beard net before checking food temperatures in the kitchen and said, Because I had really bad allergies this week and did not want to scratch and contaminate the food. He stated he notified the DM of his allergies before starting his shift on 11/12/25. He stated it was important to follow the beard net policy and said, To keep residents from getting sick. Residents could get sick. During an interview on 11/12/25 at 12:28 p.m., DA B stated she was most recently reeducated on the beard net policy approximately one or two months ago by the current DM. She stated all kitchen staff were responsible for following the facility's beard net policy. She stated the cooks were required to wear beard nets when handling food. She stated the DM oversaw and ensured kitchen staff wore beard nets. She stated it was important to follow the beard net policy and said, So no hair touches residents' food. Residents could become upset, and not following the beard net policy would affect their health. During an interview on 11/12/25 at 12:43 p.m., DA C stated she was most recently reeducated on the beard net policy two years ago by the former DM. She stated all kitchen staff were responsible for following the facility's beard net policy before entering the kitchen. She stated the cooks were required to wear beard nets when handling food. She stated the cooks and DM oversaw and ensured kitchen staff wore beard nets. She stated it was important to follow the beard net policy and said, To protect the food and make sure hair does not fall on residents' meals and trays. Residents could be at risk of getting sick. During an interview on 11/12/25 at 12:52 p.m., the DM stated he was educated on the beard net policy. He stated he most recently reeducated the kitchen staff on the beard net policy in the summer of 2025. He stated all kitchen staff and anyone who stepped into the kitchen were required to wear a beard net or facial hair must be clean shaven when handling food. He stated he oversaw and ensured kitchen staff wore beard nets by conducting rounds several times per shift. He stated he observed [NAME] A not wearing a beard net when [NAME] A was checking the food temperatures in the kitchen before lunch meal service, did not do anything, and did not know why he did not do anything. He stated it was important to follow the beard net policy and said, You don't want to contaminate the food with hair and other contaminants. Residents could be at risk of foodborne illness and other diseases. Review of the facility's Staff Attire policy, revised 01/2025, reflected, Procedures: 1. All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained.</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, 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 1 (Resident #1) of 6 residents reviewed for infection control. The facility failed to ensure staff wore PPE when entering Resident #1's room on 11/12/25 at 8:00 a.m. This failure could place residents at risk of cross-contamination and infection. Findings include: Review of Resident #1's admission Record, dated 11/14/25, reflected she was an [AGE] year old female who was admitted to the facility on [DATE]. She had medical diagnoses including dementia (a set of symptoms that cause a significant decline in cognitive abilities like memory, thinking, and reasoning, to the point that it impairs daily life), weakness and COVID-19. Review of Resident #1's Quarterly MDS Assessment, dated 11/03/25, reflected she had a BIMS score of 2, which indicated she had severe cognitive impairment. Resident #1's COVID-19 vaccine was also not up to date. Review of Resident #1's Care Plan, revised 09/06/25, reflected she had diagnosis of COVID-19 and was at risk for developing respiratory complication including but not limited to impaired oxygen exchange and dehydration and decrease in mobility. One of the interventions included, isolation with droplet precautions in place, ensure proper signage is on doors and proper donning and doffing (putting on and taking off) is occurring when entering and exiting room or unit. Review of Resident #1's Electronic Monitoring Footage, dated 11/12/25 at 8:00 a.m., reflected Resident #1 was lying in bed in her room. A female staff member entered Resident #1's room with no PPE, placed a meal tray on Resident #1's bed side table next to Resident #1, woke Resident #1 and said, Buenos Dias (Good Morning), explained to Resident #1 that the meal tray was on the bed side table next to her, and exited her room. Review of the facility's Infection Report for November 2025 reflected Resident #1 had COVID-19 and was placed on droplet precautions on 11/05/25. Resident #1's infection resolved on 11/15/25. During an observation and interview on 11/12/25 at 10:31 a.m., Resident #1's room door was closed. There was a posting on her door that indicated she was on droplet precautions and staff were required to don and doff PPE before entering and exiting her room. There was a supply bin filled with PPE next to her room. Resident #1 was lying in an upright position in bed. Resident #1 stated she observed staff wear PPE before entering her room. During an interview on 11/12/25 at 1:25 p.m., Resident #1's RP stated she observed in-person and most of the time on camera the facility staff wearing PPE before entering and exiting Resident #1's room. During an interview on 11/13/25 at 3:11 p.m., LPN D stated she was most recently reeducated on infection control by the weekend supervisor in the Summer of 2025. She stated nurses were required to don PPE before entering and exiting residents' droplet precaution room. She stated that the Wound Care Nurse was the Infection Preventionist. She stated the Wound Care Nurse oversaw and ensured staff followed infection control protocols. She stated it was important to don PPE before entering and exiting residents' droplet precaution room and said, So we don't spread infection. Residents could be at risk of worsening sickness. During an interview on 11/14/25 at 10:29 a.m., the Wound Care Nurse stated she was the Infection Preventionist. She stated staff were reeducated on infection control quarterly by her and the ADONs. She stated she was unsure when she most recently reeducated staff on infection control. She stated staff were provided with the don and doff PPE posting or were required to notify the nursing staff if they did not know how to don and doff PPE. She stated she expected staff to don PPE, enter the room, provide care or service, doff PPE, perform personal hand hygiene and exit the room whenever residents were on droplet precautions. She stated that her, the DON, and ADONs oversaw and ensured staff followed infection control policy by conducting rounds every hour. She stated she knew it was important to don PPE before entering and exiting residents' droplet precaution room and said, To protect yourself and the resident. Residents could be at risk of developing infection if staff were not donning and doffing. During an interview on 11/14/25 at 10:49 a.m., ADON E stated the Wound Care Nurse was the Infection Preventionist. He stated he or the Wound Care Nurse reeducated staff on infection control monthly. He stated he expected staff to wear full PPE, which included gown, gloves, mask and face shield. He stated everyone at the facility was responsible for following the donning and doffing PPE policy. He stated it was important to don PPE before entering and exiting residents' droplet precaution room and staid, Primarily for infection control, and to prevent spread of infection, such as COVID-19. Residents could be at risk of possible infection. During an interview on 11/14/25 at 11:35 a.m. ADON F stated the Wound Care Nurse</p>		