STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455390	A. Building B. Wing	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Vida Nursing and Rehab-San Antonio	5027 Pecan Grove 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all allegations involving abuse, neglect, and misappropriation were reported immediately, but no later than 2 hours after the allegation was made to the State Survey Agency for 1 of 8 residents (Resident #1) reviewed for abuse and neglect. The facility did not report to the State Survey Agency (HHSC) an alleged romantic relationship between Resident #1 and LVN A, as reported by Resident #1 to the DON, and LVN A to the ADON. This failure could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm. The findings included: Record review of Resident #1's admission record, undated, reflected a [AGE] year-old resident with an initial admission of 02/03/2025 and diagnoses including acute respiratory failure with hypoxia (a condition where the lungs cannot adequately oxygenate the blood) and quadriplegia (paralysis of all four limbs). Record review of Resident #1's BIMS Assessment reflected that Resident #1 had a BIMS score of 9, reflecting moderate cognitive impairment. Record review of Resident #1's Care Plan, undated, did not indicate that Resident #1 had a history of sexually inappropriate behavior toward residents or staff. Record review of Resident #1's Progress note, dated 05/13/2025, reflected that Resident #1 requested to be sent to the emergency room for evaluation that day due to started to cough while asleep and had difficulty catching his breath. Record review of the Intake Investigation Worksheet #1009602 dated 0514/2025 revealed facility reported residents' allegations of abuse and neglect and not wanting to return to the facility. Neither self-report nor addendums revealed concern for possible sexual abuse or exploitation. Record review of the Provider Investigation Report (PIR), dated 05/19/2025, reflected that Resident #1 complained about the facility at the hospital, but when the DON went to speak with him at the hospital, Resident #1 declined the complaints, saying he was angry and just wanted to go to where LVN A worked. The PIR did not reflect possible sexual abuse or exploitation.Interview on 07/10/2025 at 3:55 PM, the facility's previous DON (DON C), who was the DON at the facility at the time of the incident, stated that she initially she went to the hospital to check on Resident #1 because of the complaints he had at the hospital of the facility, including pest control issues and being left soiled for a long time. Resident #1 recanted the complaints to DON C, stating he was just upset due to them firing LVN A, and wanted to live where she was because they were in a relationship. DON C stated that she had heard from Resident #1's Stepsister, LVN B, that she had a suspicion Resident #1 and LVN A were having a relationship. DON C stated she had reported LVN A to the Texas Board of Nursing on 05/22/2025 out of an abundance of caution due to the allegations of LVN A having a physical relationship with Resident #1. DON C stated LVN A had not been fired, but had changed her employment to PRN status. Interview on 07/10/2025 at 4:22 PM, LVN B stated she had informed the DON, at the time, DON C, that she felt Resident #1 was having a relationship with LVN A. LVN B stated that everything seemed normal at first for a working relationship between a nurse and a patient, but toward the end of LVN A working at the facility, she became hostile toward LVN B. LVN B stated that she did not know the extent of their relationship and whether it was sexual or not, because shortly after going to the hospital, Resident #1 ceased communication with LVN B and she had not heard from him since. LVN B stated she was aware Resident #1 had similar behaviors at a previous facility, but had not told any facility staff or administration of these behaviors. Interview on 07/10/2025 at 4:42 PM, ADON D stated she never had a concern of a sexual relationship between Resident #1 and LVN A. She stated she observed that Resident #1 and LVN A were friendly and LVN A would hang out in his room frequently. ADON D stated she did complete a verbal conversation with LVN A, and reprimanded her for spending too much time with Resident #1 and that she should focus on all residents equally. ADON D stated that DON C returned from the hospital after visiting Resident #1 and identified concerns of a possible inappropriate relationship. ADON D stated that staff members were questioned and interviewed regarding potential sexual abuse and/or inappropriate relationships between residents and staff. ADON D stated that during investigations she informs the ADM and the ADM reports to the state as necessary. Interview on 07/11/25 at 10:30 AM, Resident #1 stated that he did not have a relationship with LVN A. Resident #1 stated that they were friends and stated, she was my age, and we were able to click together. Resident #1 denied any sexual encounters and inappropriate interactions with LVN A. Interview on 07/11/2025 at 2:40 PM, the ADM stated that, during the course of the investigation of Resident Neglect for Resident #1, she should have identified that an allegation of inappropriate relationship between Resident #1 and LVN A should have been recognized as possible abuse