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	02/13/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remains as free of accident hazards as is possible; and to ensure resident receives adequate supervision to prevent accidents for 1 of 3 residents (Resident #1) reviewed for accidents and hazards in that: The facility failed to ensure Resident #1's environment was free of hazards and Resident #1 was adequately monitored. On 2/4/2026 Resident #1 told CNA A she wanted to kill herself. Resident #1 was discovered harming herself by cutting her right wrist with a shaving razor on 2/5/2026. The noncompliance was identified as PNC. The IJ began on 2/4/2026 and ended on 2/8/2026. The facility had corrected the noncompliance before the survey began. This failure could result in residents experiencing suicidal ideations being at risk for harm, injuries, and death. The Findings:Record review of Resident #1's admission Record dated 2/5/2026 revealed she was admitted on [DATE] with diagnoses of mild cognitive impairment, depression, and anxiety disorder. Record review of Resident #1's admission MDS dated [DATE] revealed her BIMS was 8/15 (moderate cognitive impairment), she had no behaviors, she was ambulatory, she required partial/moderate assistance for personal hygiene (shaving), her active diagnoses was anxiety disorder and depression. Record review of Resident #1's consolidated orders for February 2026 revealed an order of Buspirone HCl oral tablet 10 mg give 1 tablet by mouth three times a day for anxiety and Sertraline HCl oral tablet 50 mg give 1 tablet by mouth one time a day for depression. Record review of Resident #1's MAR revealed she was administered Buspirone HCl oral tablet 10 mg give 1 tablet by mouth three times a day for anxiety and Sertraline HCl oral tablet 50 mg give 1 tablet by mouth one time a day for depression, as ordered. Record review of Resident #1's care plan dated 2/6/2026 revealed she required antidepressants, and anti-anxiety medications. Resident #1's care plan revealed Resident #1 wanted to end her life. Interventions included: notify physician, attempt to refocus Resident #1 to something positive when behavior occurs, SW/staff will counsel with Resident #1 and listen to her concerns, make referral to psychology consult, send emergency room for evaluation and treatment, treatment to left wrist per order. Suicidal Ideation, intervention was SW/staff will counsel with Resident #1 and listen to her concerns, staff will encourage Resident #1 to attend activities to help occupy their mind and time, staff will encourage friends/family to visit resident, staff will give medication as ordered, staff will monitor for effectiveness and side effects for medication. The care plan did not mention a history of suicidal ideation. Record review of Resident #1's mood assessment dated [DATE] revealed a score of 9, meaning minimal depression. Record review of Resident #1's SBAR dated 2/4/2026 at 3:48 PM revealed a mental status change. Suicidal ideation started on 2/5/2026, treatment was ordered and Resident #1 was sent to emergency room for treatment. The MD and family were notified on 2/5/2026 at 10:42 AM; signed by LVN B on 2/5/2026. Record review of Resident #1's transfer form dated 2/5/2026 at 10:57 AM revealed suicidal ideation. The resident expressed multiple times that she wanted to harm herself. The resident was noted with (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a superficial scrape on her left wrist. The resident sent out for evaluation of suicidal thoughts. The resident was placed on one-to-one care until ambulance service arrived for transport. The MD and family were notified on 2/5/2026 at 10:45 and 11:00 AM; signed by LVN B on 2/5/2026. Record review of self-reported incident filed by the ADM of the facility dated 2/6/2026 at 10:28 AM revealed the Brief summary of the report: on 2/5/2026 at approximately 10:30 am the ADM learned of Resident #1's intent to self-harm, as reported to the DON. LVN B stated she received report from CNA C the resident had voiced wanting to kill herself while in the dining room and decided not to have dinner and went to her room. LVN B immediately initiated monitoring one to one by assigning CNA A in the resident's room. LVN B, the AM-Charge Nurse, reported the incident to the NP and DON. The NP ordered the residents to be sent out to hospital for treatment and evaluation. The police/behavioral team came in to assess the incident and determined that residents did not meet criteria due to her denial of self-harm. LVN B reported to have secured a razor blade from the resident's room, as she had voiced wanting to shave her legs. LVN E, PM-Charge Nurse, reported Resident #1 informing the police that she was upset because she thought they were in a relationship, when she saw a male resident talking to other women. Resident #1 was seen ambulating and communicating with the male resident that may have caused her emotional imbalance. LVN E administered her night medications, routinely monitoring, and the resident slept well overnight. On 2/6/2026, LVN B and the ADON learned of the resident having a self-inflicting superficial abrasion to her left wrist while sitting in the dining room with other staff members and residents. Resident #1 was tearful because she did not want to get anyone in trouble, claiming the injury was only a scratch. When asked about the razor, she reported having hidden a razor in a drawer in her room and then moved it to the bag on her walker. LVN B notified the MD, and orders to discharge resident to hospital were received. Resident #1 was discharged to hospital for evaluation and treatment where she was admitted . Observation on 2/8/2026 at 8:30 AM with Resident #1, at the hospital behavioral unit, she revealed her left wrist, underside, had a superficial 1 inch scratch. Resident #1 stated she did scrap herself due to a broken heart and she knew that was wrong. Resident #1 stated she did not blame the facility. During an interview on 2/8/2026 at 8:30 AM Resident #1 stated she asked CNA A for a razor to shave her legs and received 2 shavers with no supervision. Resident #1 stated she was upset because a male resident had broken her heart. Resident #1 stated she did scrap herself due to a broken heart and she knew that was wrong. Resident #1 stated she did not blame the facility. During an interview on 2/8/2026 at 10:15 am LVN B started on 2/4/2026 at 5:30 PM, during dinner, CNA C reported to LVN B that Resident #1 did not want to be here (kill herself) anymore. LVN B had CNA A follow Resident #1 to her room and picked up a razor and brought it to LVN B. LVN B stated she called the DON, NP and ordered Resident #1 to the hospital due to suicidal ideation, then called 911. CNA A was with Resident #1 until the police came. LVN B stated the police had talked to Resident #1, and the police stated she did not meet qualifications to be sent out to emergency room-hospital. LVN B stated Resident #1 had told police she was upset because a male resident broke up with her and did not want to hurt herself. LVN B stated she had texted the DON about the police response and Resident #1 did not meet requirements. LVN B stated that when the ambulance was called the police arrived. This was protocol the police/behavior response team stated for SI. LVN B stated the next day, 2/5/2026 at 10 AM, Resident #1 was downstairs, with the ADON staying Resident #1 until the ambulance arrived at the facility. Resident #1 had a razor in her hand, and had a superficial scratch on her left wrist. LVN B stated she Buspirone HCl oral tablet 10 mg give 1 tablet by mouth three times a day for anxiety and Sertraline HCl oral tablet 50 mg give 1 tablet by mouth one time a day for depression took the razor form Resident #1, notified the NP, ordered Resident #1 to go (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to hospital for evaluation of suicidal ideation. LVN B stated she started the SBAR on 2/4/2026, then the police/behavioral team arrived and stated Resident #1 did not [NAME] the requirements. Then when Resident #1 cut herself on 2/5/2026, she completed the SBAR. During interview on 2/8/2026 at 3:50 PM with CNA C stated she wrote a statement for ADM. CNA C stated she was stayed with Resident #1 on 2/4/2026, when she had stated she did not want to kill herself, CNA C stated she went reported this to LVN B that was in the dining room. CNA C stated CNA A was stayed with Resident #1 while she reported this incident to LVN B. During an interview on 2/8/2026 at 3:55 PM CNA A stated she gave Resident #1 two shavers on 2/4/2026. Resident #1 stated she wanted the shavers to shave her legs and did not supervise her with the razors. CNA A stated on Wednesday (2/4/2026), around dinner, Resident #1 stated she wanted to kill herself and the aide reported that to LVN B. CNA A stated while in Resident #1's room she removed a razor from her room and was with her until the police arrived. CNA A stated she had forgotten that she gave Resident #1 two shavers. During interview on 2/9/2026 at 1:40 PM with CNA E stated the police were at the facility when she arrived for her shift at 6:00 PM. CNA E stated the police had stated Resident #1 was not a risk for SI. CNA E stated she monitored Resident #1 and she had slept and rested all night. Resident #1 was back to normal. CNA E stated the staff were supposed to stay with residents if they ask for a shaver, and staff dispose of it in sharps container, after use. CNA E stated residents are not supposed to have sharp objects. During interview on 2/9/2026 at 2:03 PM the ADON stated on 2/5/2026 soon after the morning meeting, at 10:35 AM, CNA D had brought him a razor from Resident #1 and stated she was going to kill herself. The ADON stated he stayed with Resident #1, until the ambulance came to transport her to hospital for suicidal ideation. The ADON stated the ADM and DON were also waiting and talking with Resident #1. ADON stated the staff were supposed to stay with residents if they ask for a shaver, and staff dispose of it in sharps container, after use. ADON stated residents are not supposed to have sharp objects. ADON stated no resident had attempted SI before at facility. ADON stated he was not aware of Resident #1's SI before 2/5/2026. Record review of policy revealed resident suicide threats must be taken seriously and immediately reported to the nurse supervisor/charge nurse. Immediately notify the physician, staff member must remain at 1:1 with the resident until the threat of immediate danger has changed. Record reviews of policy for razors revealed no razors to be given to residents, residents that can and choose to shave independently must be monitored, and staff will properly dispose of used razors. PNC IJ verification: During an interview on 2/9/2026 at 3:28 PM with the ADM stated she was with Resident #1 on 2/5/2026 in morning and talked with Resident #1. The ADM stated Resident #1 had 2 razor blades she was provided by CNA A. The ADM stated CNA A was suspended on 2/5/2026 pending an investigation. The ADM stated staff were in-serviced on abuse/neglect, razors, and suicidal ideation, dated 2/5/2026 to 2/8/2026. The facility took the following actions to ensure residents are adequately supervised to prevent suicide attempts: This was all verified by surveyors by observations, interviews and record review. Record review of Resident #1's comprehensive care plan was revised on 2/6/2026 to address the resident's statements and actions that she wanted to end her life. Resident #1 was placed on 1:1 on 2/5/2026 until EMS arrived. The MD and Resident #1's RP/family were notified. The SW met with Resident #1, she was referred to psychological services, a urine test was ordered, and she was sent to the emergency room for evaluation and treatment. The 1:1, psychological referral and urine test was verified for Resident #1's orders. The urine test was negative. The facility suspended CNA A on 2/5/2026 pending an investigation and submitted a self-report for the incident to HHSC. Record review was verified of CNA A suspension on time records and was disciplined. Record review the facility assessed the other residents in the facility for suicidal ideations and ensured all sharp objects (continued on next page)

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