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	05/13/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 3 residents (Resident #1) reviewed for medical records accuracy.The facility failed to ensure Resident #1's Nursing Assistant ADL Flow Sheets were accurately documented from 4/13/2026 to 5/12/2026.This failure could place residents at risk for an incomplete clinical picture and errors in care and treatment.The findings included: Record review of Resident #1's face sheet, dated 5/12/2026, revealed a [AGE] year-old male admitted on [DATE] with diagnoses which included: cerebral infarction (stroke), type 2 diabetes mellitus (body does not use insulin effectively), and need for assistance with personal care. Record review of Resident #1's quarterly MDS assessment, dated 4/1/2026, revealed a BIMS score of 07 which indicated severe cognitive impairment. His functional abilities were supervision or touching assistance with bathing and personal hygiene/toileting. Record review of Resident #1's undated ADL self-care performance deficit care plan revealed Bathing: requires staff x1 for assistance and Bathing: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. If diabetic, the nurse will provide toenail care was listed with a frequency of Monday-Wednesday-Friday during the day shift. Record review of Resident #1's ADL completed bath activity for the last 30 days from 4/13/2026-5/12/2026 did not reveal the resident's scheduled bathing days. There were seven showers, baths, or sponge baths documented in the electronic medical record in the last 30 days from 4/13/2026-5/12/2026. There were no showers, baths, sponge baths, or refusals entered for seven scheduled M-W-F bath days in the electronic medical record. Days missing a record include, 4/15/2026, 4/17/2026, 4/22/2026, 4/24/2026, 4/29/2026, 5/4/2026, and 5/8/2026. During an interview on 5/12/2026 at 4:18 PM, CNA A stated baths were recorded in the POC and sheets. CNA A stated, [Resident #1] received a bed bath on 4/11/2026 and that she mis-marked it as a shower. CNA A stated she always offered Resident #1 a bath on his scheduled day but that he refuses if its during the smoke break. During an interview on 5/12/2026 at 4:18 PM, CNA B stated baths were recorded in the POC. CNA B stated, [Resident #1] received peri-warm wipe down [bed bath] on 4/11/2026 instead of a bath because he wanted to go to a smoke break. During an interview on 5/13/2026 at 12:01 PM, LVN C stated CNAs documented showers/baths in the POC and that missing records looked like the residents were being neglected. During an interview on 5/13/2026 at 12:15 PM, LVN D stated missing records, can cause issues if a resident states that did not have a shower but did receive one. Some residents with dementia could forget. During an interview on 5/13/2026 at 12:25 PM, the ADON stated staff were trained to record baths/showers in the POC. The ADON stated missing records, could be a resident refusal, not offered, or didn't document. During an interview on 5/13/2026 at 1:17 PM, the DON stated, staff were trained to fill out the [shower task] form, let the nurse know, and document in POC if showers/baths were given or refused. The DON stated she would be implementing a new shower sheet but that the POC was the official record. The DON said the impact of missing records was the residents electronic medical record was, inaccurate documentation. Things can be missed. Showers could possibly be (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

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	05/13/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	missed. Record review of the facility's undated policy titled Documentation revealed: Goal1.The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.2.The facility will ensure that information is comprehensive and timely and properly signed.Procedure7.Document or check information on flow sheets each shift or as appropriate for the care or treatment being monitored.