STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455467	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Nursing & Rehabilitation	8223 Broadway San Antonio, TX 78209

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs for 1 of 5 residents (Resident #74) reviewed for call light. Resident #74's call light was not placed within reach of her . This failure could place residents who used call lights for assistance in maintaining and/or achieving independent functioning, dignity, and well-being.Findings included: Record review of Resident's #74's face sheet, 4/14/2026, revealed a [AGE] year-old female admitted on [DATE] with diagnoses that included: [Chronic obstructive pulmonary disease] (is a chronic inflammatory lung disease that causes obstructed airflow from the lungs), Diabetes is a chronic metabolic disease characterized by high blood glucose (sugar) levels, occurring when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it makes) and Fibromyalgia (is a chronic disorder characterized by widespread musculoskeletal pain, fatigue, sleep disturbances, and cognitive issues). Review of Resident # 74's admission MDS assessment dated [DATE] revealed a BIMS score of 15, suggesting the patient was cognitively intact. Record review of Resident #74's care plan dated 3/11/2026 revealed keep call light within reach of resident Observation and interview on 04/14/2026 at 10:30 AM of Resident #74's room revealed that the call light was not visible. Further observation revealed Resident #74's call light was wound around the call light box . Resident #74 stated she did not have a call light and did not know where her call light was. During an interview on 04/14/2026 at 10:35 AM with CNA B, confirmed Resident #74's call light was on the floor; and she wound the call light on the call light box that morning when she made the bed and probably forgot to leave it with in the residents reach . CNA B noted that the lack of accessibility of a call light could negatively affect any resident if they needed assistance. Interview on 04/14/2026 at 11:00 am with LVN A, she stated Resident #74's call light was out of reach of Resident #74. However, she confirmed that it was not normal nursing practice for one resident to be left without a call light. LVN A remarked that the absence of the call light could constitute potential harm if the resident needed assistance in an emergency. Interview on 04/14/26 at 12:00 PM with the DON, she stated the facility had a call light policy and staff has been in-serviced many times to keep call light within residents' reach. The DON also confirmed that Resident # 74's care plan addressed the need for a call light within reach. She said she did not know why it was not within Resident # 74's reach but would ensure all staff was in-serviced on this process again. Record review of the facility policy's. Communication-Call System, revised 6/2020, revealed Call cords will be placed within the resident's reach in the resident's room.

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure residents have a right to personal privacy for 1 of 5 residents (Resident #7) reviewed for resident rights, in that: CNAs D and E did not completely close Resident #7's privacy curtain while providing incontinent care for the resident. This deficient practice could place residents who received incontinent care at-risk of loss of dignity, embarrassment, and a decline in quality of life.The findings were: Record review of Resident #7's face sheet, dated 04/16/2026, revealed an admission date of 07/31/2025, and a readmission date of 01/15/2026, with diagnoses that included: Type 2 diabetes mellitus (high level of sugar in the blood), Dementia (decline in cognitive abilities), Major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood) Record review of Resident #7's Quarterly MDS assessment, dated 02/18/2026, revealed the resident had a BIMS score of 14, which indicated intact cognition, and he was always incontinent of bladder and frequently incontinent of bowel. Record review of Resident #7's care plan, dated 11/26/2025, with a problem of The resident has foley Catheter to help manage his bladder function. The foley requires regular care to prevent infection, skin problems or other complications. and an intervention of Monitor/record/report to MD for signs and symptoms of UTI (urinary tract infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse,increased temperature, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Observation on 04/16/2026 at 11:05 a.m. revealed CNAs D and E provided catheter/incontinent care care for Resident #7. During care CNAs D and E did not pull the curtain at the end of the bed to offer privacy to the resident. Further observation revealed Resident #7 could have been seen by someone opening the room's door and his genitals were fully exposed. During an interview with CNAs D and E on 04/17/2026 at 11:34 a.m., CNAs D and E stated the privacy curtain was not closed while they provided care for Resident #7 but should have been. CNAs D and E stated they had received resident rights training from the DON and ADON. During an in interview with the DON and the Administrator on 04/16/2026 at 3:55 p.m., they stated privacy must be provided during nursing care and Resident #7's privacy curtain should have been closed completely. They stated Resident rights training had been provided for the staff within the current year. Record review of the facility's policy titled, Resident rights, dated 08/2020, revealed, State and federal laws guarantee certain basic rights to all residents of the Facility. These rights include, but are not limited to, a resident's right to: [.] E. Privacy and confidentiality.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that PRN (as needed) orders for psychotropic medications were limited to fourteen days for 1 (Resident #5) of 25 residents reviewed, in that: Resident #5's PRN order for ABH gel (Ativan/Benadryl/Haldol) was not limited to fourteen days. This deficient practice could result in residents who receive PRN psychotropic medications being administered such medications for staff convenience rather than resident need.The findings were: Record review of Resident #5's face sheet, dated 04/17/2026, revealed the resident was admitted to the facility on [DATE] with diagnoses including: generalized anxiety disorder, major depressive disorder, psychotic disturbance, and altered mental status. Record review of Resident #5's quarterly MDS, dated [DATE], revealed a BIMS score of 0 which indicated severe cognitive impairment. Record review of Resident #5's care plan, revised 04/13/2026, revealed, The resident requires psychotropic medications. Record review of Resident #5's order summary as of 04/17/2026, revealed an order with start date 04/09/2026 and no end date, Ativan-Benadryl-Haldol: ABH Gel 1-25-1 Apply 1 application transdermally every 8 hours as needed for Anxiety/Agitation/Restlessness. During an interview with the DON on 04/17/2026 at 1:18 p.m., the DON stated the ABH gel was a psychotropic medication, and the PRN order should have an end date of no more than fourteen days past the start date. Record review of the facility policy, Physician Orders, revised 06/2020, revealed, The Medical Records Department will verify that physician orders are complete, accurate, and clarified as necessary.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care for 1 of 2 residents (Resident #87) reviewed for new admissions. The facility failed to develop a baseline care plan within 48 hours of admission for Resident #87. This failure could lead to residents not receiving necessary care and decreased quality of life.Findings included: Record review of Resident #87's face sheet, dated 4/14/2026, revealed that a [AGE] year-old male was admitted to the facility on [DATE]. Relevant diagnoses included Chronic Obstructive Pulmonary Disease (is a progressive, treatable lung disease that causes obstructed airflow, making it difficult to breathe), Diabetes mellitus (is a chronic metabolic disease characterized by high blood sugar levels resulting from the body's inability to produce enough insulin or use it effectively), and Hypertension (is a chronic condition where blood forces against artery walls too strongly) Record review of Resident #87's baseline care plan report, printed 4/14/2026, revealed no care plan to address the hearing deficit or the use of hearing aids. Record review of Resident #87's admission MDS admission assessment dated [DATE] revealed a BIMS score of 13, which indicated his cognition was intact. Record review of hospital admission clinicals for Resident #87 dated 4/3/2026, revealed: Hearing impaired / wears hearing aids in both ears. Record review of Resident #87's admission MDS assessment dated [DATE] revealed that under section D0300, hearing aids were selected. Observation on 4/15/2025 at 10:20 AM revealed that Resident #87 was wearing hearing aids in both ears. Interview with Resident #87 on 4/15/2026 at 10:30 AM stated he arrived at the current facility with hearing aids and used them for years due to his hearing loss. In an interview with MDS Nurse on 4/15/2026 at 10:40 AM, she stated that a baseline care plan should include anything a resident needs to receive proper care, including allergies, fall risks, skin conditions, code status, hospice (if applicable), bowel and bladder needs, pain, and nutrition. She also stated that the current care plan was insufficient to provide care for Resident #87. In an interview with the DON on 4/15/2026 at 11:11 AM, after reviewing Resident #87's baseline care plan together, she stated the document should have contained medications, transfer status, therapy needs, etc. She reported that the potential harm to residents from an insufficient care plan was that they might not receive proper care. Review of the facility's policy document titled Care Planning, Comprehensive Person-Centered (revised June 2020), which revealed, The facility will develop a person-centered Base Care Plan for each resident within 48 hours of admission .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for the front lobby and utility hallway for 1 of 1 facility reviewed for accident hazards. 1.The women's restroom in the front lobby, which was open and accessible to residents, did not have grab bars, a means to call for assistance, the locking mechanism was a latch on the inside of the door, and the door was difficult to open from the inside. 2.The men's restroom in the front lobby, which was open and accessible to residents, did not have grab bars or a means to call for assistance. These deficient practices could result in physical harm to residents. Observation on 04/16/2026 at 3:35 p.m. revealed the women's restroom in the front lobby was open, unlocked, and accessible by residents. Further observation revealed the restroom did not have grab bars, did not have a means to call for assistance, the locking mechanism was a latch on the inside of the door, and the door was difficult to open from the inside. Observation on 04/16/2026 at 3:38 p.m. revealed the men's restroom in the front lobby was open, unlocked, and accessible by residents. Further observation revealed the restroom had grab bars installed but did not have a means to call for assistance should the need occur. During an interview with the Maintenance Assistant on 04/16/2026 at 3:40 p.m., the Maintenance Assistance confirmed that the women's restroom in the front lobby was open, unlocked, and accessible by residents, did not have grab bars, did not have a means to call for assistance, the locking mechanism was a latch on the inside of the door, and the door was difficult to open from the inside. The Maintenance Assistant stated that a resident may not be able to utilize the toilet safely without grab bars, would not be able to call for assistance if needed, and staff would not be able to reach a resident in need of assistance because the door latched from the inside and was not able to be opened from the outside while the latch was engaged. The Maintenance Assistant also stated that the difficulty in opening the door could result in a resident not being able to leave the restroom. The Maintenance Assistant also confirmed that the men's restroom was open, unlocked, and accessible by residents and did not have a means to call for assistance should the need occur. The Maintenance Assistant stated the restrooms should not be accessible to residents due to safety concerns. Observation on 04/16/2026 at 4:00 p.m. revealed a room in the utility hallway which did not have a doorknob or means to lock it contained a number of stored items including three containers labeled biohazard which held syringes that had been utilized. Further observation revealed the utility hallway was accessible by walking from a resident hallway and was accessible by any resident who could ambulate. During an interview with the Maintenance Assistant, at the same time as the observation, the Maintenance Assistant stated the biohazard containers with used syringes should not have been in an area accessible by residents. During an interview with the DON on 04/17/2026 at 1:18 p.m., the DON stated the restrooms should not have been accessible by residents and that they had been secured. The DON also stated that the biohazard material should not have been stored in an area accessible by residents and had been moved to a secure storage area. Record review of the facility policy, Resident Rooms and Environment, revised 08/2020, revealed The Facility provides residents with a safe, clean, comfortable, and homelike environment. Facility Staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. This shall include ensuring that residents can receive care and services safely and that the physical layout of the Facility maximizes resident independence and does not pose a safety risk.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure incontinent care was provided in accordance with appropriate treatment and service practices to prevent urinary tract infections and to restore continence to the extent possible for 1 of 2 residents (Residents #7) reviewed for incontinent care and catheter care, in that: While providing incontinent care for Resident #7, CNA D used a back-and-forth motion to clean Resident #7. These deficient practices could place residents at-risk for infection and skin break down due to improper care practices. The findings were: Record review of Resident #7's face sheet, dated 04/16/2026, revealed an admission date of 07/31/2025, and a readmission date of 01/15/2026, with diagnoses that included: Type 2 diabetes mellitus (high level of sugar in the blood), Dementia (decline in cognitive abilities), Major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood) Record review of Resident #7's Quarterly MDS assessment, dated 02/18/2026, revealed the resident had a BIMS score of 15, which indicated no cognitive impairment, and was indicated to occasionally be incontinent of bowel and had an indwelling catheter. Record review of Resident #7's care plan, dated 11/26/2025, reflected a problem of The resident has foley Catheter to help manage his bladder function. The foley requires regular care to prevent infection, skin problems or other complications. and an intervention of Monitor/record/report to MD for signs and symptoms of UTI (urinary tract infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Observation on 04/16/2026 at 11:09 a.m. revealed CNAs D and E provided catheter/incontinent care for Resident #7. During care CNA D used a back and forth motion to wipe the resident instead of a front to back motion. She wiped Resident #7's penis from base to tip instead of tip to base. During an interview with CNA D on 04/17/2026 at 11:34 a.m., CNA D stated the proper motion to clean a resident's penis was front to back or tip to base. She did not realize she was using the wrong motion and stated she was nervous. She stated she received training in incontinent care within the year from the DON and ADON. During an in interview with the DON and the Administrator on 04/16/2026 at 3:55 p.m., they stated the correct motion to clean a resident was front to back to prevent the contamination of the urinal tract with fecal matter and prevention of infection. They stated the staff was provided incontinent care training and their skills were checked annually and as needed. Record review of facility's policy titled, Clinical competency validation catheter: indwelling urinary care of, dated 09/23/2025, revealed, Male: washes around catheter insertion site and then from the tip of the penis down to the body.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were stored in locked compartments and permit only authorized personnel to have access to the keys for 1 of 5 residents (Resident #83) reviewed for medication storage, in that: The facility failed to ensure medication Vick's (nasal decongestant) was not left on Resident #83's bedside table. This failure could place residents at risk for not receiving the intended therapeutic benefit of their medications as ordered.The findings were: Record review of Resident #83's face sheet, dated 3/25/26, revealed a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses that included Dependence on renal dialysis (means relying on regular, life-sustaining, procedure to remove waste and excess fluid when kidneys fail) , Depression (is a mood disorder that causes a persistent feeling of sadness and loss of interest) and Anxiety disorder mental health condition characterized by excessive uncontrollable fear or worry that persists for six months or more, significantly interfering with daily life). Record review of Resident #83's admission MDS, dated [DATE], revealed a BIMS score of 3, which indicates severe cognitive impairment. Record review of Resident #83's physician orders for April 2026, reviewed on 4/14/26, did not reveal an order to self-administer medications or an order for Vicks VapoRub Record review of Resident #83, physician orders for April 2026, did not reveal an order for Vicks VapoRub. Observation on 04/14/2026 at 9:40 a.m. of Resident #83's room revealed there was a jar of Vicks on the nightstand. Interview with Resident #83 on 4/14/26 at 12:15 p.m., the Resident stated her family purchased Vicks for her and brought it sometime this weekend . The Resident further stated that no one had given her a self-medication assessment. Interview with LVN A on 4/14/26 at 1:30 p.m., LVN A confirmed she was assigned to Resident #83 and verified that a jar of Vicks was on the resident's bedside table. She stated Resident #83 had not received a self-medication assessment and should not have access to medication for self-administration, as this poses a risk of improper use by the Resident or accidental ingestion by others due to lack of secure storage and cognition. Interview with the DON on 04/14/26 at 9:55 a.m., the DON reported a jar of Vicks was found on Resident #83's bedside table. The DON explained that no medication should be left on a resident's bedside table without a self-medication assessment, as this may lead to the resident taking more than the prescribed dosage. Record review of the facility's policy titled Medication Storage, revised January 2026, revealed, Medications must be stored securely to prevent unauthorized access, diversion, loss, contamination, or misuse.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the safe and sanitary storage of residents' food items in 1 of 5 residents' refrigerators (Resident #29) reviewed. The personal refrigerator in Resident #29's room contained food items that were unlabeled and undated. This deficient practice could put residents at risk of foodborne illness from consuming spoiled food.The findings were: Record review of Resident #29's face sheet, dated 4/14/2026, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Major Depressive Disorder, (is a serious mental health condition characterized by a persistent low mood, loss of interest in activities), Hypertension (a chronic condition where the force of blood against artery walls is consistently too high), and Benign Prostatic Hyperplasia (non-cancerous condition in men where the prostate gland becomes enlarged as they get older). Record review of Resident #29's BIMS assessment, completed 1/24/26, revealed a BIMS score of 15, which indicated intact cognition. Observations on 4/14/2026 at 11:45 a.m. revealed that the personal refrigerator for Resident #29 contained an unlabeled, undated storage container with unidentified fuzzy, slimy patches in shades of green, black, and white. Further observations on 4/14/2026 at 11:55 a.m. of the personal refrigerator of Resident #29 revealed that the unlabeled, undated storage container was still present. Interview with Resident #29 on 4/14/2026 at 12:30 p.m. revealed that he was unaware of the unlabeled container in his personal refrigerator. Resident #29 stated he stored snacks in his personal refrigerator but was unaware that items had to be dated. Interview on 04/14/2026 at 12:45 p.m. with CNA D, who stated she was assigned to Resident #29 and confirmed that the personal refrigerator in Resident #29's room contained a container that was undated and unlabeled. She did not know who was responsible for checking the president's personal refrigerator for expired food but would check with the charge nurse. Interview with LVN C on 4/14/2026 at 1:00 p.m. revealed she was the assigned nurse for Resident #29 and confirmed there was an unlabeled and undated storage container in the personal refrigerator for the resident. LVN C added all staff were responsible for removing undated and unlabeled food items from residents' personal refrigerators weekly. Resident #29 risked some form of food-borne illness by possibly consuming food that was unlabeled and undated. During an interview with the DON on 04/14/26, at 1:15 p.m., the DON confirmed that perishable food and drinks in residents' personal refrigerators should be labeled and dated to prevent residents from consuming spoiled food. The DON stated that all staff were responsible for removing undated, unlabeled food items from residents' refrigerators weekly, including assisting families in labeling and dating food items brought in. The DON stated that families sometimes bring food for residents without notifying the nursing staff. She added that her charge nurses were responsible for overseeing this task, and her ADONs would be monitored at random. Record review of the facility policy, Personal Refrigerator , revised 1/1/2026, revealed: Facility staff will monitor the resident refrigerator weekly .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to 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 disease and infection for 1 of 5 residents (Resident #7) reviewed for infection control, in that: 1. The facility failed to ensure CNA D changed her gloves and sanitized her hands after cleaning Resident #7 and before touching the clean brief and pad. 2.The facility failed to ensure CNAs D and E wore a gown while providing catheter care for Resident #7 who was on enhanced barrier precaution. These failures could place residents at-risk for infection due to improper care practices. The findings were: Record review of Resident #7's face sheet, dated 04/16/2026, revealed an admission date of 07/31/2025, and a readmission date of 01/15/2026, with diagnoses that included: Type 2 diabetes mellitus (high level of sugar in the blood), Dementia (decline in cognitive abilities), Major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood) Record review of Resident #7's Quarterly MDS assessment, dated 02/18/2026, revealed the resident had a BIMS score of 15, which indicated no cognitive impairment, and was indicated to occasionally be incontinent of bowel and had an indwelling catheter. Record review of Resident #7's care plan, dated 11/26/2025, reflected a problem of The resident has foley Catheter to help manage his bladder function. The foley requires regular care to prevent infection, skin problems or other complications. and an intervention of Monitor/record/report to MD for signs and symptoms of UTI (urinary tract infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. 1 Observation on 04/16/2026 at 11:09 a.m. revealed while providing incontinent care for Resident #7, CNA D did not change her gloves and sanitize her hands after cleaning the resident and before touching the clean brief and pad. A sign for enhanced barrier precautions was seen by the door of the resident's room and on top of Resident #7's bed. Personal protective equipment was available at the entrance of the room. During an interview on 04/16/2026 at 11:34 a.m. with CNA D, she stated she did not change her gloves and sanitize her hands after cleaning Resident #7 and before touching the clean brief, while providing incontinent care for Resident #7. She said she was nervous and forgot. She stated she received infection control training within the year. 2, Observation on 04/16/2026 at 11:09 a.m., revealed while providing catheter care for Resident #7, CNAs D and E did not gown up to enter the room and provide care. Resident #7 was on enhanced barrier precaution due to his indwelling catheter. interview on 04/16/2026 at 11:34 a.m. with CNAs D and E revealed they stated they forgot Resident #7 was on enhanced barrier precaution. They stated they had received training on enhanced barrier precautions. Interview on 04/16/2026 at 3:55 p.m. with the DON and the Administrator, revealed they stated the staff needed to wear gown and gloves for resident on enhanced barrier precaution and to sanitize hands between change of gloves for the prevention of infection to the residents but also the staff. The DON stated infection control training was provided was provided and skills were checked annually. Review of facility's policy, titled Standard and Enhanced Precautions , dated 04/01/2024, revealed For resident who EBP (enhanced barrier precaution) are indicated, EBP should be used when performing the following high contact resident care activities: [.] changing briefs or assisting with toileting [.] Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventialtor. Review of facility's policy, titled Hand Hygiene , dated 06/2020, revealed Facility staff and volunteers must perform hand hygiene procedures in the following circumstances including but not limited to [.] after removing personal protective equipment [.] [NAME], [NAME] (7) [NAME]-[NAME], morgane (34788) - Urinary Catheter or UTI 04/16/2026 11:09 AM [NAME] (Resident #7)Incontinent care/catheter care provided by CNA Zulay [NAME] and CNA [NAME] CNAs did not put a gown on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455467	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Broadway Nursing & Rehabilitation	8223 Broadway San Antonio, TX 78209

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	before providing the care. An EBP sign was at the door and on the wall behind the resident's bed. PPE was available at the door. CNAs did not close the privacy curtain to provide privacy during the care. The resident was naked and could have been seen from the door if somebody opened the door during the care. The resident's roommate was laying on his bed watching television during the care. CNA Zulay wipe the resident's penis from base to tip CNA Zulay did not change her gloves and sanitize her hands after cleaning the resident's buttocks and before placing the clean brief and pad under the resident. 11:34AM Interview with CNAs Confirmed findings. Confirmed receiving training from the ADON and DON, confirmed having her skills checked and revealed she was very nervous and forgot. [NAME], [NAME] (7) [NAME]-[NAME], morgane (34788) - RESIDENT NOTE No Notes