STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455533	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windcrest Nursing and Rehabilitation	8800 Fourwinds Dr San Antonio, TX 78239

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on observation, interviews and record reviews, the facility failed to ensure residents had the right to be free from abuse, neglect, and misappropriation of property for 1 of 6 residents (Resident #2) reviewed for abuse, in that: The facility did not properly monitor or put in place preventative measures for Resident #2, who had a severe cognitive impairment, to prevent an act of sexual abuse by Resident #1 on 02/13/25, when he kissed Resident #2, and 02/14/25, when he fondled Resident #2. An IJ was identified on 02/27/25. The IJ template was provided to the facility on [DATE] at 06:18 PM. While the IJ was removed on 03/01/25 at 05:00 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm. This failure could result in residents suffering injury, a diminished quality of life, and psychosocial harm. The findings were: Record review of Resident #1's Admission Record reflected he was a [AGE] year-old male initially admitted [DATE] and readmitted [DATE]. It further reflected he had diagnoses to include dementia (group of symptoms affecting memory, thinking and social abilities) and major depressive disorder. Record review of Resident #1's quarterly MDS assessment, dated 01/23/25, reflected a BIMS score of 14 out of 15, indicating intact cognition. (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: 455533	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2025
NAME OF PROVIDER OR SUPPLIER Windcrest Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 8800 Fourwinds Dr San Antonio, TX 78239	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's care plan, reflected, The resident has a behavior problem [Resident #1] goes into other residents' room, and sits in there while the resident is not in the room r/t confusion . Resident masturbates in empty rooms and during showers and when staff is providing peri care often. Resident makes sexually inappropriate comments and attempting to inappropriately touch female staff . Sexually inappropriate behaviors with female resident touching females and private areas breast and peri are in common areas at times., initiated 05/16/24 and revised 02/24/25. With interventions to include if reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident, initiated 05/16/24 and Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed., initiated 05/16/24. 1:1 when out of bed and room, initiated 02/11/25. During an interview on 03/03/25 at 01:48 PM, MDS nurse Q revealed the intervention for 1:1 when out of bed and room, dated on 02/11/25, was entered on 02/14/25 and accidentally back dated for 02/11/25. Record review of Resident #2's Admission Record reflected she was an [AGE] year-old female initially admitted [DATE] and readmitted [DATE]. It further reflected she had diagnoses to include dementia (group of symptoms affecting memory, thinking and social abilities), cognitive communication deficit, restlessness and agitation, generalized anxiety disorder, and senile degeneration of brain. Record review of Resident #2's quarterly MDS assessment, dated 12/12/25, reflected a BIMS score of 99, indicating resident was unable to complete the interview. It further reflected Resident #2 had a short and long-term memory problem and was severely cognitively impaired (never/rarely made decisions). Record review of Resident #1's Nurse's Note on 08/09/24 at 02:18 PM, authored by ADON D, reflected, assigned CNA for 8/9/24 7-3 reported during resident's shower the resident fondle himself, grab her breast and attempted to kiss her neck. CNA expressed to the resident that his behavior was inappropriate, and she would stop the shower to get someone else. resident stated he liked the CNA and wanted to finish; shower was completed by this time. resident was quickly taken to room where [Resident #1's RP] was present, CNA informed [Resident #1's RP] of [Resident #1]'s inappropriate touching of CNA and fondling of himself. [Resident #1's RP] stated he does that all the time, it's ok. we pay people to please him sometimes. CNA informed [Resident #1's RP] that staff is not [Resident #1]'s privately paid employee, and that is inappropriate for this facility. [Resident #1's RP] stated she would remind [Resident #1]. Record review of Resident #1's Nurse's Note on 01/21/25 at 01:48 PM, authored by LVN N, reflected, [Resident #1] was found in empty room on back of b hall masturbating. Was alone and CNA were able to take him to is room, he did not want to go back to room . Explained to [Resident #1] that he cannot be in another room in dark he needed to be in his room or let staff know where he was. He also did this yesterday that is went to another room in back of [Activity Room] where we had to look for him. Record review of Resident #1's Nurse's Note on 01/22/25 at 04:00 PM, authored by ADON E, reflected, [Resident #1] was noted to be in empty room on crescendo masturbating, resident was also seen bent forward in wheelchair trying to clean the floor. Explained to resident that for safety reasons staff needs to be aware of whereabouts. Resident expressed understanding. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Nurse's Note on 02/11/25 at 05:18 PM, authored by ADON D, reflected, [Resident #1] seen by this nurse, other staff, and several visitors sitting in main common area/foyer next to female resident from [room number and bed identifier] holding and rubbing her forearm while she groped/fondled his penis. this nurse informed both residents this was not allowed in the common/public area. The female resident removed her hand from the male resident's crouch/groin area but left it on his thigh. this resident nodded his head and stated yes, (he) understands, thank you. they continued to sit in the common area/foyer watching the television. Record review of Resident #1's Nurse's Note on 02/13/25 at 03:45 PM, authored by ADON E, reflected, this nurse was informed this resident was witnessed blowing kisses to and then kissing a female resident who is incapable of consent on the mouth in the common area/foyer. this resident was informed not to kiss or have physical contact with this resident because she is unaware and incapable of consenting to any physical or sexual advances. this resident nodded his head, and said yes, ok. this resident remained in the common area/foyer and the other resident was removed from the area. [Resident #1's RP] called and informed of this incident and of actions facility will be taking on this repetitive matter; also informed if resident persisted with inappropriate sexual behavior after unsuccessful md/np-psych consults, possible med adjustments that resident may be discharged . [Resident #1's RP] acknowledged understanding of information provided. [Resident #1's RP] stated she spoke with him about [Resident #1's] inappropriate behavior and thought he wasn't going do anything else. And [Resident #1's RP] wanted to talk with the social worker about getting in contact with the psych doctor. this nurse let the [Resident #1's RP] know that the nurse manager will reach out to the psych np with these concerns but if she wanted to speak with the psych np, her visiting days are Tuesdays and Wednesdays, as it is not protocol for staff to give out the numbers. [Resident #1's RP] voiced understanding. [Resident #1's RP] asked to have this resident contact her. Record review of Resident #1's Nurse's Note on 02/13/25 at 03:45 PM, authored by the DON, reflected, New orders obtained from [NP F] to refer to psych services and initiate Depakote 125mg BID due to inappropriate sexual behavior. [Resident #1's RP] informed and consented to treatment. Record review of Provider Investigation Report, dated 02/14/25, reflected the [DOR] witnessed [Resident #1] caressing [Resident #2's] breasts. on 02/14/25 at 10:30 AM. Record review of Record of In-Service for Abuse/Neglect for All Departments, dated 02/13/25, reflected Neglect: HHSC defines neglect as, the failure to provide goods or services, including medical services that are necessary to avoid physical or emotional harm, pain, or mental illness. Abuse is also resident to resident contact. This document further reflected 8 out of 90 current facility staff had not signed this In-Service. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a Psych note, dated 02/14/25, reflected [Resident #1] reports to I am fine. Staff report [Resident #1] is experiencing sexually inappropriate behaviors. This is first time he is having these behaviors since admission to this facility. He was observed by staff, blowing kisses to [Resident #2] and then he started kissing on her mouth without consent. [Resident #2] is A x O x 1, and incapable to make any decisions or consent. Staff witnessed this incident occurred in the common area/foyer. Redirections non effective, [Resident #1] still want to involved with [Resident #2] physically. [Resident #1's RP] made aware about incident happened by facility staff. [Resident #1] intending to go in the same room. Closed observation placed by PCP. We also reported to (local police). Although patient is A x O x 4, patient intentionally provided false information to police officer, and he was defending himself by accusing [Resident #2] and staff, when they came in the facility. Attempted interview with Resident #2 was on 02/24/25 at 08:29 AM. Resident #2 was unable to participate in interview due to confusion. During an interview on 02/25/25 at 11:30 AM, the SW revealed Resident #1 was alert and oriented with a BIMS of 15 and misread the situation. She revealed Resident #2 was not able to consent to this incident. The SW further revealed this was not typical behavior for Resident #1. She further revealed Resident #1 was on a one to one when resident was not in his room. She revealed it was Resident #1's responsibility to let someone know when he came out of the room. During an interview on 02/25/25 at 03:37 PM, CNA A revealed she was not trained about any resident needing a one to one. She revealed Resident #1 had been more touchy last week (week of 02/17/25). She revealed Resident #1 can't come out of his room. She revealed Resident #2 tended to be around the facility by herself and was not able to make her own decisions. During an interview on 02/25/25 at 04:36PM, Resident #1's RP could not recall any incident in August 2024 or any incident before last week with inappropriate behavior. She revealed Resident #1 did not think about the consequences. The RP revealed it was disgusting they didn't contact her about any other incident because she would have gotten this resident some help. During an interview on 02/25/25 at 05:25 PM CNA B stated he was a new hire, had started a week and a half ago, and was not aware of any residents being on a 1:1. He further revealed he did not know who Resident #1 was and would not be able to recognize him if Resident #1 was in the hallway. During an interview and observation on 02/26/25 at 08:08 AM, Resident #1 was in his room alone. Resident #1 stated, I'd rather not in response to an attempted discussion on his recent resident to resident incidents. Resident #1 stated he was being treated OK. During an interview on 02/26/25 at 11:01 AM, CNA C revealed she worked last week, shadowing CNA B, and was not aware of any resident having a one to one. She revealed she was trained on ANE and how to handle behaviors, but nothing for any specific behaviors for specific residents at the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 02/26/25 at 12:50 PM, ADON D revealed on 02/11/25, Resident #1 had a consensual act with Resident #3 but it was inappropriate because it was in public and the facility told both residents this could not happen in public. ADON D revealed on 02/13/25, Resident #1 and Resident #2 were facing each other in a common area. She revealed a visitor reported to ADON D that Resident #1 was kissing Resident #2 and Resident #1 was told to scoot back from Resident #2 as Resident #2 could not consent. She further revealed on 02/14/25 Resident #1 was found fondling Resident #2's breasts. She revealed Resident #1 had been going to empty rooms to masturbate. ADON D confirmed her note on 08/09/24 occurred and revealed when she showered Resident #1 he also did this to her. She further revealed she thought she documented when he did this to her and there should have been interventions created for these behaviors of Resident #1. She revealed it was important for ADON D to document this to prevent anything from happening with female residents. She revealed it was possible the facility had interventions after these incidents of inappropriate behavior by Resident #1, but she could not remember exactly what. She revealed these incidents were discussed in morning meetings. ADON D revealed after the 02/14/25 incident, she communicated with B wing nurses and a B wing CNA. She revealed she hoped this nursing staff passed on this information from shift to shift. She revealed they were responsible for reading the 24-hour report or verbally passing this information on for the next shifts. She revealed she did not think there was any oversight for this process, but it was common sense. She further revealed A wing CNAs should know about the 02/14/25 incident to make sure Resident #1 did not go back into Resident #2's room. She revealed there was a doctor's order to check on Resident #1 every hour, but after nurses checked if resident was in the room or not, there was not any follow up actions for the staff to follow and there should be. During an interview on 02/26/25 at 02:47 PM, ADON E revealed they had a one to one for Resident #1 over the weekend of 02/15/25, which was an initial intervention. She revealed this was documented in the MAR that they checked on Resident #1 every hour (constantly watching where he was at). She revealed someone had to keep an eye on him so Resident #1 did not go into any ladies' rooms or go close to other females. She revealed management only told staff that needed to know, like A wing nurses, about the 02/14/25 sexual abuse incident, but was unaware if A wing CNAs were told. She revealed she expected the nurses to educate the CNAs and was unsure if anyone was overseeing this process. ADON E revealed when Resident #1 was going down to other rooms to masturbate, they educated Resident #1 that he had privacy in his room and redirected him appropriately. ADON E revealed there was no history of Resident #1 wandering into female's rooms. She was not aware of Resident #2 being kissed by Resident #1 on 02/13/25. She revealed there was probably some intervention on 02/13/25, but she could not recall. She revealed she was not aware of the incident between Resident #1 and Resident #3, but that Resident #3 was alert and oriented. She revealed she was unaware of any August incidents with Resident #1. She revealed this was not a reoccurring behavior for resident that she was aware of. During an interview on 03/03/25 at 01:48 PM, MDS nurse W and MDS nurse Q revealed for Resident #1 the interventions for his masturbation incidents were to intervene as necessary and protecting rights of residents. MDS nurse Q revealed the intervention for 1:1 when out of bed and room, dated on 02/11/25, was entered on 02/14/25 and back dated for 02/11/25 accidentally. They further revealed interventions were put in Resident #1's care plan after the team met in the morning meeting and decided this intervention would be appropriate. They revealed the DON oversaw this. They revealed it was important for interventions to be followed because it was a part of the plan for what they have done for the resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/06/25 at 04:52 PM, Resident #2's RP revealed she did not feel like Resident #2 had been neglected by the facility. She revealed she thought the facility was doing their best to protect Resident #2. She revealed Resident #2 was not alert and oriented and could not make conscious decisions for daily tasks. During an observation on 02/25/25 at 3:00 PM, Resident #1 was in a private room with no roommate and the door was open. Resident #1 was observed seated with a walker in front of him. Resident #1 was alone and without any staff supervision. It was further observed that no staff were in the hallway. Record review of facility's policy, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, reflected, 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anything including, but not necessarily limited to: b. other residents . 7. Implement measures to address factors that may lead to abusive situations, for example: a. adequately prepare staff for caregiving responsibilities. The Administrator was notified on 02/27/25 at 06:18 PM an IJ was identified on 02/27/25 due to the above failures. The IJ template was provided to the facility on [DATE] at 06:18 PM and the POR was accepted on 02/28/25 at 03:26 PM. Date: 2/27/2025 PLAN OF REMOVAL FOR IMMEDIATE JEOPARDY To Whom it may concern, Summary of Details which lead to outcomes. On 02/24/2025, a complaint survey was initiated at [The Facility]. On 02/27/2025, A surveyor provided an IJ Template notification that the Survey Agency has determined that the conditions at the center constitute immediate jeopardy to resident health. The notification of the alleged immediate jeopardy states as follows: The facility failed to ensure that residents had the right to be free from abuse. The facility failed to provide necessary monitoring for Resident #1 to protect Resident #2 from sexual abuse. Identify residents who could be affected. All Residents have the potential to be affected. On 02/27/25, the resident census was 51. Identify responsible staff/ what action taken: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Start date: 02/27/25. Completion date: 02/27/25 Responsible: Administrator/Designee Action: The Administrator/designee will place the male resident involved on 1:1 supervision immediately to ensure no sexually inappropriate behavior occurs. This 1:1 supervision will be provided until alternate placement for resident #1 is secured or he is cleared by the medical director or psychiatrist. Start date: 02/18/25. Completion Date: 02/27/25 Responsible: DON/Designee Action: Resident #2 was evaluated by the psychiatric nurse practitioner. The psychiatric nurse practitioner did not note a deviation of the resident's baseline behavior or mood. Resident #2 has an order for behavior monitoring that occurs every shift and is ongoing to monitor for mood changes. A review of this monitoring reveals no deviation of the resident's baseline behavior or mood. Start date: 02/27/25. Completion date: Ongoing Responsible: Administrator/Designee Action: The Administrator/Designee will interview all team members to determine if team members have knowledge of any inappropriate sexual behavior of male residents that may have occurred and has not been reported. If any are identified, an immediate assessment and a self-report will be completed. Start date: 02/27/25. Completion Date: 02/27/25 Responsible: Regional Director of Clinical Services Action: The Administrator and Director of Nursing will be educated by the Regional Director of Clinical Services on reportable sexually inappropriate behavior: 1. Residents must have the capacity to make decisions to give consent for sexual activity 2. Sexual activity without consent or cognitive ability to give consent is a reportable event (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, or mental abuse, including abuse facilitated or enabled using technology. 4. Sexual abuse is defined as non-consensual sexual contact of any type with a resident. Staff should monitor for any behaviors that may provoke a reaction by residents or others, which include, but are not limited to, sexually aggressive behavior such as saying sexual things and inappropriate touching/grabbing. 5. Any resident displaying sexually inappropriate behaviors involving non-cognitive residents will be placed on 1:1 supervision until evaluated by the primary provider and/or psych provider and deemed safe to have 1:1 supervision discontinued. Start date: 02/26/25. Completion Date: 02/28/25 Responsible: DON/Designee Action: DON/Designee will provide training for all team members on reportable sexual inappropriate behavior to include: 1. Team members educated on male residents' 1:1 status and sexually inappropriate behavior (i.e., touching, inappropriate sexual touching, and kissing towards residents who are unable to consent. 2. Sexual activity without consent or cognitive ability to give consent is a reportable event. 3. Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, or mental abuse, including abuse facilitated or enabled using technology. 4. Sexual Abuse: is defined as non-consensual sexual contact of any type with a resident. Staff should monitor for any behaviors that may provoke a reaction by residents or others, which include, but are not limited to, sexually aggressive behavior such as saying sexual things and inappropriate touching/grabbing. (continued on next page)

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

5. Training will include reporting all sexually inappropriate behavior to the Admin/DON immediately and intervening to prevent any injury. This training will be provided upon hire, annually and as needed. Full-time staff will be educated by end of day 02/28/25. PRN will be educated before the beginning of their next scheduled shift. Initial education may occur verbally via telephone, and in-person education will be completed prior to the beginning of their next scheduled shift. Any staff that are on leave or unavailable will receive the education before the beginning of their next scheduled shift.

6. Education was provided to all staff regarding residents who do not have the cognitive ability to give consent.

Start date: 02/26/25.

Completion date: 02/27/25

Responsible: Administrator/Designee

Action: The Administrator/Designee conducted safe surveys with all cognitively intact residents residing on the A and B wings. The following questions were asked:

1. Question 1. Has another resident ever touched you inappropriately or made unwelcome advances towards you? If yes, tell me what happened, when it happened, if you reported it and who you reported it to.

2. Question 2. Do you feel safe?

No further incidences of sexually inappropriate behavior were identified.

Start Date: 02/26/25.

Completion Date: 02/27/25

Responsible: DON/Designee

Action: DON/Designee completed full skin assessments for non-cognitively intact residents residing on A and B wings. No evidence of sexually inappropriate behavior, such as bruising of the genitals or inner thighs, bleeding, irritation, or pain of the anus or genitals, or bloody, stained, or tattered undergarments, was identified. No behavioral signs of sexual abuse, such as new increased agitation, anxiety, social withdrawal, or fear, were identified.

Start Date: 02/27/25.

Completion Date: 03/27/27

Responsible: DON/Designee

Action: DON/Designee will monitor process compliance and understanding daily during the morning clinical process and room rounding observations.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Start Date: 02/27/25. Completion Date: 02/27/25 Responsible: Administrator Action: An Ad Hoc QAPI committee meeting was held with the Medical Director, Dr. G, regarding the current IJ and plan of correction. Start Date: 02/27/25. Completion date: 02/27/25 Responsible: Administrator/Designee Action: Results of in-servicing and interviews will be reviewed during the monthly QA meeting scheduled on 03/26/25. POR verification reads as follows: Record review of the facility's POR Binder dated 2/25/2025 revealed 51 residents were identified as vulnerable for ANE. Record review of Resident #2's PHQ-9 assessment (standardized tool used for screening, diagnosing, and measuring the severity of depression) reflected a score of 0, indicating no depression. Record review of Resident #2's doctor's orders reflected, BEHAVIOR MONITORING FOR: mood changes, verbal aggression .for every shift, as of 06/01/21, . BEHAVIOR MONITORING FOR: anxiety/restlessness . for every shift, as of 02/10/25, [Psych] to eval and treat . as of 12/20/22. Record review of the facility's POR binder reflected statements from staff regarding question do you have knowledge of any inappropriate sexual behavior made by male residents towards other residents that has not been reported? If so, what happened? revealed staff responded in a negative for inappropriate sexual behaviors. Record review of the safe Survey Team Member Interview dated 02/27/25 revealed the Administrator documented no to the question. Record review of the safe Survey Team Member Interview dated 02/27/25 revealed the Activities Assistant documented no to the question. Record review of the safe Survey Team Member Interview dated 02/27/25 revealed LVN Q documented no to the question. Record review of the safe Survey Team Member Interview dated 02/27/25 revealed the Social Worker documented no to the question. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455533	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2025
NAME OF PROVIDER OR SUPPLIER Windcrest Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 8800 Fourwinds Dr San Antonio, TX 78239	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the safe Survey Team Member Interview dated 02/27/25 revealed the Housekeeping Director documented no to the question. Record review of the safe Survey Team Member Interview dated 02/27/25 revealed LVN N documented no to the question. Record review of the facility's in-service record dated 02/27/25 revealed, residents must have the capacity to make decisions to give consent for sexual activity Further record review revealed the Administrator and the DON received the in-service. Record review of the facility employee roster, dated 02/24/25, reflected 94 employees which included all departments, Administration, Nursing, Dietary, Therapy, and Housekeeping. Record review of the facility's in-service titled Sexual Abuse dated 2/26/2025 revealed, sexual inappropriate behavior . sexual activity without consent is a reportable behavior . all reports of potential abuse / neglect must be verbally reported immediately no matter the time (24 / 7) day night weekends, holidays, vacations, etc., to the abuse coordinator (the Administrator). AND One to one in-service dated 2/26/2025 revealed Resident #1 is to remain on one-to-one observation at all times and monitored for inappropriate sexual behaviors. Team-member may sit outside his room in the hallway to provide privacy but once he leaves his room the team-member must escort him and continue to monitor him. Record review of the facility's in-service titled Sexual Abuse ANE and One-to One, dated 2/26/2025, revealed 94 of 94 employees received both in-services which included the following employees: CNA A, CNA B, CNA C, ADON D, ADON E, LVN H, CNA J, CNA K, LVN L, CNA M, LVN N, LVN O, LVN P, LVN Q, LVN R, CNA S, LVN T, CNA U, CNA V, CNA X, CNA Y, LVN Z, CNA AA, CNA AB, LVN AC, CNA AD, CNA AE, CNA AF, LVN AG, CNA AH, CNA AI. Record review of nursing schedules for the month of January 2025 reflected 3 nursing shifts which included 7AM to 3PM, 3PM to 11PM, and 11PM to 7AM. Further record review revealed the 7AM to 3PM shift comprised of 5 nurses and 7 CNAs, the 3PM to 11PM shift comprised of 5 nurses and 7 CNAs, and the 11PM to 7AM shift had 2 nurses and 3 CNAs. Observation on 02/28/25 at 03:35 PM revealed the BOM was sitting, in the hall across from Resident #1. During an interview and observation on 02/28/25 at 03:36 PM, the BOM stated she was on 1:1 monitoring for Resident #1 and kept a form (1:1 sheet) she wrote on. The BOM was observed writing what she observed while she conducted the 1:1 monitoring of Resident #1. The BOM stated she did receive the in-service training on Resident #1's sexually inappropriate behavior. The BOM stated if she saw Resident #1 with inappropriate sexual behavior, she would intervene and notify DON. During an interview on 03/01/25 at 11:57 AM, the DON stated Resident #2 was ordered to receive psychiatric follow up. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/01/25 at 11:30 AM, the Administrator stated she and her designee interviewed all the current staff and revealed no evidence of sexual abuse and stated if any staff were not interviewed, they would not be able to assume a duty. During an interview on 02/28/25 at 03:50 PM, LVN N (who worked 7AM-3 PM) stated if she saw a resident with inappropriate sexual behavior, she would intervene and notify DON. During an interview on 02/28/25 at 04:21 PM, LVN R (who worked weekends) stated they had not seen any inappropriate sexual behavior. LVN R stated if they saw a resident with inappropriate sexual behavior, she would intervene and notify DON. During an interview on 02/28/25 at 04:30 PM, ADON D stated she had not seen any inappropriate sexual behavior. ADON D stated if she saw a resident with inappropriate sexual behavior, she would intervene and notify DON. During an Interview on 02/28/25 at 04:58 PM, Receptionist S stated he had not seen any inappropriate sexual behavior. Receptionist S stated if he saw a resident with inappropriate sexual behavior, he would intervene and notify DON. During an interview on 02/28/25 at 05:29 PM, LVN T stated she had not seen any inappropriate sexual behavior. LVN T stated if she saw a resident with inappropriate sexual behavior, she would intervene and notify DON. During a joint interview with LVN L and Receptionist S on 02/28/25 at 05:30 PM, LVN L stated he had not seen any inappropriate sexual behavior. Receptionist S stated if he saw a resident with inappropriate sexual behavior, he would intervene and notify DON. During an interview with Laundry Aide AL on 2/28/2025 at 5:54 PM Laundry Aide AL stated she had not seen any inappropriate sexual behavior. During an interview on 2/28/2025 at 06:00 PM PT AK stated he had not seen any inappropriate sexual behavior. PT AK stated if he saw a resident with inappropriate sexual behavior, he would intervene and notify DON. During an interview on 03/01/25 at 11:33 AM, the Administrator stated she received ANE prevention and reporting training from the Regional Director of Clinical Services to include sexual abuse incidents. During an interview on 03/01/25 at 11:33 AM, the DON stated she received ANE prevention and reporting training from the Regional Director of Clinical Services to include sexual abuse incidents. During an interview on 03/01/25 at 11:33 AM, the DON stated she in-serviced the entire staff on Resident #1's one to one status and ANE prevention and reporting and or suspicions of sexual abuse incidents. Intermittent daily observations from 2/24/2025 - 3/3/2025 revealed Resident #1 had not exited his room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7AM-3PM Nurses = 5 During an interview on 02/28/25 at 03:40 PM, LVN P stated she works days and evenings and usually worked the 7AM to 3PM shift in the MCU. LVN P stated she had received the ANE in-service a couple of times to include the February 2025 in-service which included sexual abuse and Resident #1's 1/1 status when out of his room and if an incident of inappropriate sexual behavior was suspected, Resident would be redire [TRUNCATED]

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on interviews and record reviews the facility failed to ensure alleged violations involving neglect were reported immediately, but not later than 24 hours if the events that caused the allegation do not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures, for 1 of 8 residents (Resident #2) reviewed for reporting allegations of neglect. On 7/17/2024 CNA S assisted Resident #2 to dress while Resident #2 was seated on the bedside and during the attempt to stand CNA S and Resident #1 lost their balance and fell to the floor. CNA S failed to report the fall to the nurse, the DON, and or the Administrator. This failure could place residents at risk for neglect by not reporting allegations of ANE. The findings included: A record review of Resident #2's admission record, dated 02/25/2025, revealed an admitted [DATE] with diagnoses which included dementia (a general term for a group of brain disorders that cause a decline in cognitive abilities, such as memory, thinking, reasoning, and problem-solving), muscle weakness, and ataxic gait (an uncoordinated, awkward way of walking that's characterized by an unsteady, wide base, and irregular foot placement). A record review of Resident #2's quarterly MDS assessment dated [DATE] revealed Resident #2 was an [AGE] year-old-female admitted for long term dementia care and assessed with a BIMS score of 99 which indicated Resident #2 was not able to participate in the memory interview. Further review revealed Resident #2 had short term and long-term memory impairment, Cognitive Skills for Daily Decision Making; made decisions regarding tasks of daily life; severely impaired - never / rarely made decisions. Further review revealed Resident #2 could not dress herself and needed assistance to stand and or dress, lower body dressing: the ability to dress and undress below the waist, . sit to stand: the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. dependent: helper does all the effort. Resident does none of the effort to complete the activity A record review of Resident #2's care plan dated 2/25/2025 revealed, (Resident #2) has an ADL self-care performance deficit related to generalized weakness and diagnosis of dementia with behaviors, date initiated 05/21/2021. Residents level of function varies due to Residents disease process, level of assistance by staff can fluctuate. transfer: the resident requires extensive assistance by x1-2 staff to move between surfaces . (Resident #2) has a behavior problem r/t resident refuses or resists ADL care at times and can be verbally and physically aggressive with staff . refuses care at times. monitor, document, report PRN any s/sx of Resident posing danger to self and others (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's provider Investigation report, dated 7/25/2024, revealed the Administrator documented CNA S had assisted Resident #2 with dressing care on 7/17/2024, early in the morning, before Breakfast, when Resident #2 shifted herself during an assisted attempt to stand from the bed. CNA S stated both she and Resident fell , on 07/17/2024, she (CNA S) was getting resident up for breakfast. Resident became combative and aggressive while CNA (S) was putting on her pants. During this time, resident began to stumble over on the left and she might have hit her shoulder or arm on the windowsill or ac unit, . CNA (S) stated she used her strength to place her (Resident #2) on the floor. She went to get another CNA (X) to assist getting Resident off the floor. The administrator documented the fall was not reported to the nurse until the Administrators investigation on 7/18/2024 which was initiated due to the discovery of Resident #2's broken arm on 7/18/2024. Further review revealed the Administrator learned CNA S did not report the fall to the nurse LVN L due to her misunderstanding the definition of a fall, CNA S believed she assisted Resident #2 to the floor. During an interview on 2/28/2025 at 5:30 PM, LVN L stated he and CNA S worked the 11:00 PM to 7:00 AM shift on 7/17/2024 and he was not given a report by CNA S that Resident #2 had fallen or was assisted to the floor, and he had not assessed Resident #2 for injuries. LVN L stated had he known he would have assessed the Resident and reported to the physician. During an interview on 2/28/2025 at 3:40 PM LVN P stated she was the nurse on duty on 7/18/2024 from 7:00 AM to 3:00 PM and had not received a report that Resident #2 had a fall. LVN P stated CNA AJ had reported Resident #2 had shoulder pain when CNA AJ attempted to assist Resident with ADL care. LVN P stated she assessed Resident #2 with limited range of motion (ROM) and pain with movement of her left arm. LVN P stated she reported the findings to the physician and received orders for a mobile x-ray. LVN P stated the mobile x-ray revealed a fractured arm and reported again to the physician who ordered for Resident #2 to be sent to the hospital later that day for evaluation and treatment. LVN P stated she reported the broken arm to the DON. During an interview on 02/28/25 at 09:46 PM, CNA S stated she had assisted Resident ##2 to the floor during an attempt to stand when Resident #2 shifted her weight and they both were off balance and in an attempt to avoid a fall CNA S assisted Resident #2 to the floor. CNA S stated she believed this was not a fall and has received further training to report fall incidents to the nurse and the DON. During a joint interview on 2/28/2025 at 4:20 PM the DON and the Administrator stated Resident #2 had been assisted by CNA S sometime on 7/17/2024 between 5:30 AM and 6:00 AM when CNA S stated she assisted Resident #2 to the floor during an attempt to stand to dress her with pants. The DON stated CNA S did not report the fall to LVN L and learned of the fall from LVN P after the discovered broken arm on 7/18/2024. The Administrator stated she suspended CNA S pending an investigation, and the DON assessed peer residents on the unit and did not discover anyone else with limited ROM, pain, and provided all the staff with an in-service for reporting falls and the facility's fall protocol. The Administrator stated she learned of the injury from the DON, and she had reported the incident to the state agency on 7/18/2024 which included a provider investigation report. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy dated September 2022, revealed, Policy Statement: All reports of Resident abuse (including injuries of unknown origin), neglect, exploitation, or theft / misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation Reporting Allegations to the Administrator and Authorities: l. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law and HHSC reporting guidelines. 2. The Administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; . 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury: or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on interviews and record reviews, the facility failed to implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and timeframes to meet residents' medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment and described the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Resident #1) reviewed for care plans in that: The facility failed to implement Resident #1's comprehensive person-centered care plan intervention for 1:1 supervision for Resident #1 to have fewer episodes of sexual behaviors. This deficient practice could affect residents and place them at risk for not having their needs and preferences met. The findings included: Record review of Resident #1's Admission Record reflected he was a [AGE] year-old male initially admitted [DATE] and readmitted [DATE]. It further reflected he had diagnoses to include dementia (group of symptoms affecting memory, thinking and social abilities) and major depressive disorder. Record review of Resident #1's quarterly MDS assessment, dated 01/23/25, reflected BIMS score of 14 out of 15, indicating intact cognition. Record review of Resident #1's care plan, reflected, The resident has a behavior problem [Resident #1] goes into other residents room, and sits in there while the resident is not in the room r/t confusion . Resident masturbates in empty rooms and during showers and when staff is providing peri care often. Resident makes sexually inappropriate comments and attempting to inappropriately touch female staff . Sexually inappropriate behaviors with female resident touching females and private areas breast and peri are in common areas at times., initiated 05/16/24 and revised 02/24/25, with a goal of The resident will have fewer episodes of behaviors by review date. and an intervention to include 1:1 when out of bed and room, initiated 02/11/25. During an interview on 02/26/25 at 12:50 PM, ADON D revealed Resident #1 had inappropriate behaviors that were discussed in morning meetings. She revealed interventions were discussed and added to Resident #1's care plan to prevent anything to happen with female residents. During an interview on 03/03/25 at 01:48 PM, MDS nurse W and MDS nurse Q revealed for Resident #1 the interventions for his masturbation incidents were to intervene as necessary and protecting rights of residents. MDS nurse Q revealed the intervention for 1:1 when out of bed and room, dated on 02/11/25, was entered on 02/14/25 and back dated for 02/11/25 accidentally. They further revealed interventions were put in Resident #1's care plan after the team met in the morning meeting and decided this intervention would be appropriate. They revealed the DON oversaw this. They revealed it was important for interventions to be followed because it was a part of the plan for what they have done for the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's policy Care Plans, Comprehensive Person-Centered, revised December 2016, reflected, 8. The comprehensive, person-centered care plan will: b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on interviews, and record reviews the facility failed to provide treatment and care in accordance with professional standards of practice for 1 of 8 Residents (Resident #4) reviewed for neurological assessments after a fall. 1. On [DATE] at approximately 5:28 AM Resident #4 had an unwitnessed fall and was discovered on the floor in her bedroom, and LVN H failed to perform neurological assessments for Resident #4 at 6:45 AM, and at 7:15 AM, and failed to report to LVN I she had not assessed Resident #4 and at 8:00 AM Resident #4 and discovered deceased . 2. On [DATE] at approximately 7:40 AM LVN I assessed Resident #4 without performing a neurological assessment at 7:45 AM and did not document Resident #4's vital signs. The noncompliance was identified as PNC. The IJ began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began on [DATE]. These failures could place residents at risk for harm by lack of interventions up and including death. The findings included: A record review of Resident #4's admission record revealed an admitted [DATE] and a discharge date of [DATE] with diagnoses which included atrial fibrillation (an irregular heartbeat which can lead to blood clots in the heart, can increase the risk of stroke, heart failure and other heart-related complications), atherosclerotic heart disease (plaque buildup in artery walls, can cause a heart attack) and essential hypertension (high blood pressure.) A record review of Resident #4's quarterly MDS assessment dated [DATE] revealed Resident #4 was an [AGE] year-old female admitted for rehabilitation related to an implanted pacemaker (a device used to control an irregular heart rhythm) and was assessed with a BIMS score of 13 out of a possible 15 which indicated no cognitive impairment. A record review of Resident #4's care plan dated [DATE] revealed, The resident has an ADL self-care performance deficit r/t generalized weakness new pacemaker date Initiated: [DATE], . BEDFAST: The resident is bedfast all or most of the time. I have chosen DO NOT RESUSCITATE status Date Initiated: [DATE] . Signed DNR order is in my chart. The resident has a pacemaker Date Initiated: [DATE] . Monitor / document / report PRN any s/sx of altered cardiac output or pacemaker malfunction: dizziness, syncope (fainting), difficulty breathing (Dyspnea), pulse rate lower than programmed rate, lower than baseline B/P. The resident is at risk for falls r/t Confusion, Gait / balance problems, Incontinence, Narcotic use, Antihypertensive use, Recent Surgery, Oxygen Use. Date Initiated: [DATE] . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of Resident #4's nursing progress notes dated [DATE] revealed LVN H documented at 6:40 AM Resident #4 was discovered on the floor due to a fall, [DATE] 06:40 . Position: *Charge Nurse Created By: (LVN H) . Note Text: CNA was doing her rounds and this resident requested medication for pain. CNA told this nurse that resident wanted something for pain. This nurse retrieved pain med and went to residents' room to give to her and found her laying on the floor beside her bed. This nurse assessed resident and had CNA to go get the other nurse to help assist resident from the floor back into her bed. Resident alert and took pain medication, no apparent injuries noted at this time. Bed put in the lowest position and call light in reach. Neuro checks have been started. All parties have been notified. A record review of Resident #4's Neurological Assessment Flow Sheet dated [DATE] revealed LVN H began and continued 4 times with neuro-check assessments on [DATE] starting at 5:30 AM which included a level of consciousness, pupil response, hand grasp, motor functions, pain response, blood pressure, temperature, pulse, and respirations. Review revealed Resident #4's assessments were as follows: ,d+[DATE] at 05:30 AM alert, pupils equal reactive to light and accommodating = brisk, hand grasp = right greater than left, motor function = moves all extremities, pain response = appropriate, blood pressure = , d+[DATE], temperature = 97.1, pulse = 60, respirations 16 (per minute). ,d+[DATE] at 05:45 AM alert, pupils equal reactive to light and accommodating = brisk, hand grasp = right greater than left, motor function = moves all extremities, pain response = appropriate, blood pressure = , d+[DATE], temperature = 97.5, pulse = 62, respirations 16 (per minute). ,d+[DATE] at 06:00 AM alert, pupils equal reactive to light and accommodating = brisk, hand grasp = right greater than left, motor function = moves all extremities, pain response = appropriate, blood pressure = , d+[DATE], temperature = 97.0, pulse = 60, respirations 16 (per minute). ,d+[DATE] at 06:15 AM alert, pupils equal reactive to light and accommodating = brisk, hand grasp = right greater than left, motor function = moves all extremities, pain response = appropriate, blood pressure = , d+[DATE], temperature = 97, pulse = 58, respirations 16 (per minute). Further review of Resident #4's Neurological Assessment Flow Sheet revealed no further assessments for the scheduled 6:45 AM, 7:15 AM, the 7:45 AM, nor the 8:15 AM assessments. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:02 AM LVN H stated she works the 11:00 PM to 7:00 AM shift and on [DATE] she discovered Resident #4 on the floor next to her bed. LVN H stated she assessed Resident #4 with the assistance of CNA K and LVN L. LVN H stated she assessed Resident #4 with no injuries and Resident #4 was a/o x 3 (alert and oriented to self, time, and place) and could state she was attempting to toilet without using the call light and fell . LVN H stated she began neuro-checks and gave a report to the on-call physician and Resident #4's family. LVN H stated she began neuro-checks at 5:30 AM and per the neuro-check protocol she checked Resident #4 every 15 minutes for the first 4 assessments, then planned to check on Resident #4 every 30 minutes for the next 4 assessments, and then every hour for the next neuro-check assessments. LVN H stated she gave report to the next nurse, and could not recall her name, to include a report on Resident #4. LVN H Stated this nurse-to-nurse report usually takes from 7:00 AM to 7:20 AM. LVN H stated she left at 7:30 AM and stated before she left a CNA reported to the next nurse Resident #4 needed to be assessed. LVN H received information that a record review of Resident #4's neuro-check worksheet document dated [DATE] revealed documentation that Resident #4 was assessed for neuro checks every 15 minutes for the first four neuro checks which began at 5:30 AM and continued at 5:45 AM, 6:00 AM, and at 6:15 AM without any documentation for 6:45 AM and no further documentation. LVN H stated she could not recall why there was no assessment for the 6:45 AM assessment and the 7:15 AM assessment was the duty of the oncoming nurse. LVN H stated she may have been busy administering medications for other residents during her end of shift. A record review of LVN H's timecard dated [DATE] through [DATE] revealed LVN H clocked out at 7:50 AM on [DATE]. During an interview on [DATE] at 3:50 PM LVN I stated she was the nurse for Resident #4 on [DATE] from 7:00 AM to 3:00 PM. LVN I stated on [DATE] she was running late and arrived for her scheduled 7:00 AM to 3:00 PM shift approximately 30 minutes late, 7:30 AM. LVN I stated LVN H was irritated because many nursing interventions had been moved to her shift (11:00 PM to 7:00 AM) and she was behind in care. LVN I stated during the nurse-to-nurse report LVN H had reported Resident #4 had a fall and was followed with neuro-checks but had not reported when the next neuro check was due nor how many she had done. LVN I stated during the nurse to nurse report a CNA interrupted and asked for LVN I to assess Resident #4. LVN I stated she stopped the nurse-to-nurse report and assessed Resident #4 as sleepy with vital signs (VS) with in normal limits. LVN I stated she had not assessed Resident #4 with a neuro-check assessment, nor documented the actual numbers of the VS, nor the actual time but did state the time must have been around 7:45 AM. LVN I stated at the completion of the nurse-to-nurse report, around 8:00 AM, she returned to assess Resident #4 and discovered her unresponsive, without respirations nor a pulse. LVN I stated Resident #4 was a do-not-resuscitate (DNR) and she reported the death to the DON. A record review of Resident #4's nursing progress notes dated [DATE] revealed the DON received a report from LVN I that Resident #4 was deceased . The DON documented her assessment, 0818 (8:18 AM) this nurse was called into residents' room being informed by charge nurse that she was unable to obtain vital signs. Confirmed in medical record that resident had DNR in place. On entering resident room resident was noted to be in bed with HOB elevated above 30 degrees, oxygen in place via nasal canula, and sling in place to left upper extremity, on assessment resident was not responsive to verbal or tactile stimuli including pain with sternal rub. No rise and fall of chest noted. No pulse present. Unable to obtain blood pressure. Once again confirmed in medical record active DNR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455533	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/03/2025
NAME OF PROVIDER OR SUPPLIER: Windcrest Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 8800 Fourwinds Dr San Antonio, TX 78239	

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a joint interview on [DATE] at 12:30 PM with the Administrator and the DON, the DON stated on the morning of [DATE] she received a report from LVN I that Resident #4 was deceased , a DNR, unresponsive without respirations, and without a pulse. The DON stated she assessed and documented her assessment. The DON stated she reported Resident #4's death to the Administrator. The Administrator stated she reported the death to the state agency and directed the DON to investigate the death, assess peer residents who may be on neuro-checks for safety, and to in-service the nursing staff on neuro-check protocols. The DON stated LVN H had not reported she had not assessed Resident #4 for the 6:45 AM nor the 7:15 AM neuro-checks and LVN I had not reported she had not assessed Resident #4 with neuro-checks at 7:45 AM nor did she document the VS for that 7:45 assessment. The Administrator and the DON stated LVN H was suspended during the investigation and received an in-service for following neuro-check protocols and reporting the assessments before returning to work aafter the investigation. The Administrator and the DON stated the expectation for nursing staff was to have a Resident first plan of care to include an immediate full assessment to include neuro-checks for all residents who had an unwitnessed fall and or head strike, to immediately SBAR a physician and to continue neuro checks and follow any additional physicians' orders. The DON stated staff were also to contact family / representatives, and document in the residents' medical record and to initiate an incident report. During an interview on [DATE] at 1:20 PM Dr. G stated he was familiar with Resident #4 and his expectation for neurological assessments was for the facility to follow their protocol. Dr. G stated it would have been ideal if the nursing staff had done the assessments to include the 3 scheduled proposed assessments prior to Resident #4's discovery of being deceased . A record review of the facility's in-service titled Neuro checks dated [DATE] revealed, neurological assessments flow sheet must be initiated immediately after each unwitnessed fall or head injury. Each check should include a full set of vital signs and a head-to-toe assessment to ensure no neurological changes have occurred. IF there are changes from the baseline noted call 911 and update MD, DON, and family. Frequency of neuro-checks 15 minutes x 4; 30 minutes x4; 1-hour x4; 4 hours x4; 8 hours x3. Further review revealed 44 of 44 nursing staff signed the in-service. PNC Verification A record review of the facility's incident reports from [DATE] through [DATE] revealed no residents with lack of neuro-check assessments. A record review of the facility's in-service titled Neuro checks dated [DATE] revealed, neurological assessments flow sheet must be initiated immediately after each unwitnessed fall or head injury. Each check should include a full set of vital signs and a head-to-toe assessment to ensure no neurological changes have occurred. IF there are changes from the baseline noted call 911 and update MD, DON, and family. Frequency of neuro checks 15 minutes x 4; 30 minutes x4; 1-hour x4; 4 hours x4; 8 hours x3. Further review revealed 44 of 44 nursing staff signed the in-service. A record review of nursing schedules for the month of [DATE] revealed 3 nursing shifts which included 7:00 AM to 3:00 PM; 3 PM to 11:00 PM; and 11:00 PM to 7:00 AM. Further review revealed the 7AM to 3PM shift comprised of 5 nurses and 7 CNAs, the 3PM to 11PM shift comprised 5 nurses and 7 CNAs, and the 11PM to 7AM shift had 2 nurses and 3 CNAs. 7AM-3PM (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurses = 5 1. During an interview on [DATE] at 3:40 PM LVN P stated she works days and evenings and usually worked the 7AM to 3PM shift in the MCU. LVN P stated she had received the ANE and the neuro check in-service a couple of times to include the October in-service which included the fall protocol - if the fall was unwitnessed and or the Resident had a head injury nursing would immediately initiate neuro checks which would be done over 3 days beginning with 4 checks every 15 minutes followed by 4 checks every 30 minutes; 4 checks every hour, 4 checks every 4 hours and then 4 checks every 8 hours. 2. During an interview on [DATE] at 3:10 PM LVN N stated she had received the ANE and the neuro check in-service which was universal everywhere to include neuro checks every 15 minutes then every 30 minutes followed by every hour to include pupil reactions and to document the findings on the worksheet. 3. During an Interview on [DATE] at 3:50 PM Agency LVN I stated she had received the ANE and the neuro check in-service in [DATE] which included to initiate neuro check assessments for any Resident who had an unwitnessed fall and or a head strike. LVN I stated neuro checks included a full set of VS and Pupillary reactions. LVN I stated the neuro check worksheet would serve as documentation. LVN I stated, If it was not documented - it was not done. 4. During an interview on [DATE] at 11:20 AM ADON D stated she had received the ANE and the Neuro-check in-service in [DATE] and again in 2025 which included the fall protocol which called for initiation of neuro-checks for any unwitnessed fall and or head strike. ADON D stated the expectation was for nurses to immediately start the checks with a full set of VS 4 times every 15 minutes, 4 times every 30 minutes, 4 times every hour, and so on for 3 days or until the MD gives an order to end the checks. 5. During an interview on [DATE] at 9:10 AM LVN Z stated he worked weekend days and evenings. LVN Z stated he had received the ANE and the neuro check in-service a couple of times to include the October in-service which included the fall protocol - if the fall was unwitnessed and or the Resident had a head injury nursing would immediately initiate neuro checks which would be done over 3 days beginning with 4 checks every 15 minutes followed by 4 checks every 30 minutes; 4 checks every hour, 4 checks every 4 hours and then 4 checks every 8 hours. 6. During an interview on [DATE] at 1:02 PM ADON E stated she had received the ANE and the neuro-check in-service in [DATE] and again in 2025 which included the fall protocol which called for initiation of neuro-checks for any unwitnessed fall and or head strike, ADON E stated the expectation was for nurses to immediately start the checks with a full set of VS 4 times every 15 minutes, 4 times every 30 minutes, 4 times every hour, and so on for 3 days or until the MD gives an order to end the checks. CNAs = 7 1. During an interview on [DATE] at 2:10 PM CNA J stated she worked the 7AM -3PM shift and had received the ANE and the neuro check in service which included the fall protocol. CNA J stated if a Resident had an unwitnessed fall and or a head strike to immediately report to the nurse and to expect the nurse would perform neuro checks every 15 minutes and then every 30 minutes, and then every hour. (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. During an interview on [DATE] at 6:05 PM CNA V stated she worked the 7AM -3PM shift and had received the ANE and the neuro check in service which included the fall protocol. CNA V stated if a Resident had an unwitnessed fall and or a head strike to immediately report to the nurse and to expect the nurse would perform neuro checks every 15 minutes and then every 30 minutes, and then every hour. 3. During an interview on [DATE] at 9:12 AM CNA Y stated she worked the 7AM -3PM shift and had received the ANE and the neuro check in service which included the fall protocol. CNA Y stated if a Resident had an unwitnessed fall and or a head strike to immediately report to the nurse and to expect the nurse would perform neuro checks every 15 minutes and then every 30 minutes, and then every hour. 4. During an interview on [DATE] at 9:05 AM CNA AA stated she worked the 7AM -3PM shift and had received the ANE and the neuro check in service which included the fall protocol. CNA AA stated if a Resident had an unwitnessed fall and or a head strike to immediately report to the nurse and to expect the nurse would perform neuro checks every 15 minutes and then every 30 minutes, and then every hour. 5. During an interview on [DATE] at 9:06 AM CNA BB stated she worked the 7AM -3PM shift and had received the ANE and the neuro check in service which included the fall protocol. CNA BB stated if a Resident had an unwitnessed fall and or a head strike to immediately report to the nurse and to expect the nurse would perform neuro checks every 15 minutes and then every 30 minutes, and then every hour. 6. During an interview on [DATE] at 6:13 PM CNA FF stated she worked the 7AM -3PM shift and had received the ANE and the neuro check in service which included the fall protocol. CNA FF stated if a Resident had an unwitnessed fall and or a head strike to immediately report to the nurse and to expect the nurse would perform neuro checks every 15 minutes and then every 30 minutes, and then every hour. 7. During an interview on [DATE] at 9:53 AM CNA HH stated she worked the 7AM -3PM shift and had received the ANE and the neuro check in service which included the fall protocol. CNA HH stated if a Resident had an unwitnessed fall and or a head strike to immediately report to the nurse and to expect the nurse would perform neuro checks every 15 minutes and then every 30 minutes, and then every hour. 3PM - 11PM Nurses = 3 1. During an interview on [DATE] at 3:28 PM LVN O stated she had received the ANE and the neuro check in-service which was universal everywhere to include neuro checks every 15 minutes then every 30 minutes followed by every hour to include pupil reactions and to document the findings on the worksheet. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. During an interview on [DATE] at 4:49 PM LVN R stated he worked weekend days and evenings. LVN R stated he had received the ANE and the neuro check in-service a couple of times to include the October in-service which included the fall protocol - if the fall was unwitnessed and or the Resident had a head injury nursing would immediately initiate neuro checks which would be done over 3 days beginning with 4 checks every 15 minutes followed by 4 checks every 30 minutes; 4 checks every hour, 4 checks every 4 hours and then 4 checks every 8 hours. 3. During an interview on [DATE] at 11:46 AM LVN T stated she works evenings and usually worked the 3PM - 11PM shift. LVN T stated she had received the ANE and the neuro check in-service a couple of times to include the October in-service which included the fall protocol - if the fall was unwitnessed and or the Resident had a head injury nursing would immediately initiate neuro checks which would be done over 3 days beginning with 4 checks every 15 minutes followed by 4 checks every 30 minutes; 4 checks every hour, 4 checks every 4 hours and then 4 checks every 8 hours. 4. During an interview on [DATE] at 3:03 PM LVN Q stated she works days and could work some evenings and usually worked the 7AM to 3PM as the MDS nurse. LVN Q stated she had received the ANE and the Neuro check in-service a couple of times to include the October in-service which included the fall protocol - if the fall was unwitnessed and or the Resident had a head injury nursing would immediately initiate neuro checks which would be done over 3 days beginning with 4 checks every 15 minutes followed by 4 checks every 30 minutes; 4 checks every hour, 4 checks every 4 hours and then 4 checks every 8 hours. 5. During an interview on [DATE] at 9:09 AM LVN CC stated she had received the ANE and the neuro check in-service in [DATE] and again in 2025 which included the fall protocol which called for initiation of neuro-checks for any unwitnessed fall and or head strike, LVN CC stated the expectation was for nurses to immediately start the checks with a full set of VS 4 times every 15 minutes, 4 times every 30 minutes, 4 times every hour, and so on for 3 days or until the MD gives an order to end the checks. 6. During an interview on [DATE] at 9:34 AM LVN GG stated she had received the ANE and the neuro check in-service in [DATE] and again in 2025 which included the fall protocol which called for initiation of neuro-checks for any unwitnessed fall and or head strike, LVN GG stated the expectation was for nurses to immediately start the checks with a full set of VS 4 times every 15 minutes, 4 times every 30 minutes, 4 times every hour, and so on for 3 days or until the MD gives an order to end the checks. CNAs = 7* 1. During an interview on [DATE] at 6:00 PM CNA B stated she worked the 3PM -11PM shift and had received the ANE and the neuro check in service which included the fall protocol. CNA B stated if a Resident had an unwitnessed fall and or a head strike to immediately report to the nurse and to expect the nurse would perform neuro checks every 15 minutes and then every 30 minutes, and then every hour. (continued on next page)

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SUMMARY STATEMENT OF DEFICIENCIES
(Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0684

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

2. During an interview on [DATE] at 4:20 PM CNA K stated she worked the 3PM - 11PM shift and had received the ANE and the neuro check in service which included the fall protocol. CNA K stated if a Resident had an unwitnessed fall and or a head strike to immediately report to the nurse and to expect the nurse would perform neuro checks every 15 minutes and then every 30 minutes, and then every hour.

3. During an interview on [DATE] at 6:01 PM CNA C stated she worked the 3PM - 11PM shift and had received the ANE and the neuro check in service which included the fall protocol. CNA C stated if a Resident had an unwitnessed fall and or a head strike to immediately report to the nurse and to expect the nurse would perform neuro checks every 15 minutes and then every 30 minutes, and then every hour.

4. During an interview on [DATE] at 6:03 PM CNA U stated she worked the 3PM - 11PM shift and had received the ANE and the neuro check in service which included the fall protocol. CNA U stated if a Resident had an unwitnessed fall and or a head strike to immediately report to the nurse and to expect the nurse would perform neuro checks every 15 minutes and then every 30 minutes, and then every hour.

5. During an interview on [DATE] at 9:10 AM CNA DD stated she worked the 3PM - 11PM shift and had received the ANE and the neuro check in service which included the fall protocol. CNA DD stated if a Resident had an unwitnessed fall and or a head strike to immediately report to the nurse and to expect the nurse would perform neuro checks every 15 minutes and then every 30 minutes, and then every hour.

6. During an interview on [DATE] at 9:33 AM CNA EE stated she worked the 3PM - 11PM shift and had received the ANE and the neuro check in service which included the fall protocol. CNA EE stated if a Resident had an unwitnessed fall and or a head strike to immediately report to the nurse and to expect the nurse would perform neuro checks every 15 minutes and then every 30 minutes, and then every hour.

7. During an interview on [DATE] at 6:02 PM CNA W stated she worked the 3P - 11P shift and had received the ANE and the neuro check in service which included the fall protocol. CNA W stated if a Resident had an unwitnessed fall and or a head strike to immediately report to the nurse and to expect the nurse would perform neuro checks every 15 minutes and then every 30 minutes, and then every hour.

11PM - 7AM

Nurses = 2

1. During an interview on [DATE] at 10:23 PM LVN H stated she had received the ANE and the neuro check in-service in [DATE] and again in 2025 which included the fall protocol which called for initiation of neuro-checks for any unwitnessed fall and or head strike. LVN H stated the expectation was for nurses to immediately start the checks with a full set of VS 4 times every 15 minutes, 4 times every 30 minutes, 4 times every hour, and so on for 3 days or until the MD gives an order to end the checks.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. During an interview on [DATE] at 5:30 PM LVN L stated she had received the ANE and the neuro check in-service in [DATE] and again in 2025 which included the fall protocol which called for initiation of neuro-checks for any unwitnessed fall and or head strike. LVN L stated the expectation was for nurses to immediately start the checks with a full set of VS 4 times every 15 minutes, 4 times every 30 minutes, 4 times every hour, and so on for 3 days or until the MD gives an order to end the checks. 3. During an interview on [DATE] at 11:46 PM LVN T stated she had received the ANE and the neuro check in-service in [DATE] and again in 2025 which included the fall protocol which called for initiation of neuro-checks for any unwitnessed fall and or head strike. LVN T stated the expectation was for nurses to immediately start the checks with a full set of VS 4 times every 15 minutes, 4 times every 30 minutes, 4 times every hour, and so on for 3 days or until the MD gives an order to end the checks. CNAs = 3 1. During an interview on [DATE] at 9:46 PM CNA S stated she worked the 11PM - 7AM shift and had received the ANE and the neuro check in service which included the fall protocol. CNA S stated if a Resident had an unwitnessed fall and or a head strike to immediately report to the nurse and to expect the nurse would perform neuro checks every 15 minutes and then every 30 minutes, and then every hour. 2. During an interview on [DATE] at 1:46 AM CNA X stated she worked the 11PM - 7AM shift and had received the ANE and the neuro check in service which included the fall protocol. CNA X stated if a Resident had an unwitnessed fall and or a head strike to immediately report to the nurse and to expect the nurse would perform neuro checks every 15 minutes and then every 30 minutes, and then every hour. The noncompliance was identified as PNC. The IJ began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began on [DATE].

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 8 (Resident #5) residents in that: Resident #5 was not administered her Methadone oral tablet once in July 2024 and twice in February 2025. The effect could result in residents not provided medications as ordered. The Findings were: Record review of Resident #5's Admission Record dated 2/24/2025 reflected she was admitted on [DATE] and was [AGE] years old. Resident #5 was on hospice services, and her diagnoses included dementia, osteoporosis, abnormal posture, and osteoarthritis. Record review of Resident #5's Consolidated orders for July 2024 and February 2025 revealed an order for Methadone oral tablet 5 mg, give 1 tablet by mouth 2 times a day for pain. Medications to be given by nurse at 6:30 AM and 6:30 PM. Record review of Resident #5's MAR dated July 2024 revealed blank on MAR for 7/23/2024 for the 6:30 AM dose. Order was Methadone HCI oral tablet 5 mg, give 1 tablet by mouth 2 times a day for pain. Medications to be given by nurse at 6:30 AM and 6:30 PM. Record review of Resident #5's MAR dated February 2025 revealed blank on MAR for 2/15/2025, 5:30 AM dose and 2/18/2025 5:30 PM dose . Order was Methadone oral tablet 5 mg, give 1 tablet by mouth 2 times a day for pain. Medications to be given by nurse at 6:30 AM and 6:30 PM. Record review of Resident #5's Quarterly MDS dated [DATE] reflected she had short-term and long term memory problems, she was severely impaired for cognitive skills for daily decision making, she had upper/lower extremity impairment to both sides, she used a wheelchair, she was dependent for all ADLs, she was incontinent of bowel/bladder, she had non-Alzheimer's Dementia, osteo arthritis, she was at risk for pressure ulcers/injuries, she was taking diuretics, was on hospice services. Record review of Resident #5's care plan dated 12/24/2024reflected Resident #5 had a diagnosis for Osteoporosis: Resident with stiffness in joints, fatigue, pain, and disturbed sleep. Complaints of pain with movement to extremities at times related to diagnosis. Intervention was documented Administer pain medication ordered by MD. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #5's progress note dated, 7/23/2024 at 6:30 AM reflected, Methadone-missed. RN requested medication STAT. pain level was 0/10. Missed scheduled dose of Methadone 5mg at 6:30 am on 7/23/24. Medication not available. RN requested medication refill from hospice nurse was notified that medication was reordered and requested STAT delivery. Resident #5 assessed for pain. Resident was up in w/c, with no s/s of distress, or pain. Record review of Resident #5's progress note dated, 7/23/2024 at 10:15 AM by ADON E, reflected notified hospice nurse resident was out of her methadone pain medication. Per hospice nurse she will order medication and have it delivered STAT. Resident family at nurse station and notified of medication not given and pending delivery. During interview on 2/27/2025 at 1:58 PM DON stated Resident #5 did miss methadone that morning of 7/23/24, DON stated when hospice visits, they ask nurses how they are with medications. DON stated the facility was responsible for making sure resident medications are available per orders. Attempted interview on 2/27/25 at 2:06 PM with LVN AM, left a message. No return call. During an interview on 3/3/2025 at 1:58 PM, LVN T stated she must have forgotten to sign, but did administer medication to Resident #5 . During interview on 3/3/2025 at 2 PM with LVN H, she stated she would have to look at her schedule to see when she worked, but she gives Resident #5 her Methadone medication on time as ordered. During interview on 2/27/2025 at 2:25 PM ADON E, stated she found out, 7/23/2024 from floor LVN AM Resident #5 was missing her medication for Methadone. ADON E called hospice to ensure medications were in stock for Resident #5. ADON E stated the process was the floor nurse should let hospice or the charge nurse know that they don't have medication -Methadone. ADON E stated she reported it to the DON on 7/23/2024. During interview on 2/27/2025 at 1:30 PM DON revealed the facility was responsible for making sure residents were administered their medications as ordered. Record review of policy Refill Orders, (no date) reflected, Refill Orders -The following forms or methods are accepted means of submitting refill orders to the pharmacy: for facilities with integrated electronic records, the facility may transmit refill request via facility electronic records. In addition, the following may be used, refill order form, pharmacy link and the refill order may be called in if the circumstances require it. Refill orders will be delivered on the first respective facility run of the following business day. Urgent Orders -new orders or refills order requiring urgent delivery should be indicated in the order sheet or communicated verbally. The pharmacy had services available to deliver medications in a timely manner depending on time and location of receiving facility.