STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455742	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lev at San Antonio	7703 Briaridge Drive San Antonio, TX 78230

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455742	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lev at San Antonio	7703 Briaridge Drive San Antonio, TX 78230

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 of 5 (Resident #1) residents reviewed for medical records. The facility failed to obtain Resident #1's hospital records and a hospital discharge summary on 7/5/2025 and when the resident returned to the facility and the computerized medical record on 8/13/2025 and 8/14/2025 revealed no evidence of a hospital record or hospital discharge summary from Resident #1's hospital discharge. This failure placed residents at risk for delayed or inaccurate information of hospital history which could result in lack of continuity of care and missed history of treatment. The findings included: Record review of Resident #1's face sheet dated 8/12/2025 revealed an [AGE] year-old female, admitted on [DATE] with diagnoses which included: Type 2 diabetes mellitus, dementia with agitation and chronic kidney disease. Record review of Resident #1's annual MDS assessment, dated 7/05/2025 revealed a BIMS of 6 which indicated a severe cognitive impairment. Record review of Resident #1's progress notes dated 7/05/2025 at 2:01 p.m. revealed: Resident #1 was transported via EMS to hospital. Resident alert .EMS given report on resident fall and status. Documented by LVN A. Record review of Resident #1's progress notes dated 7/05/2025 at 7:05 p.m. revealed: Resident #1 returned to facility. No new orders from hospital. Documented by LVN A. Record review of Resident #1's computerized medical record on 8/13/2025 and 8/14/2025 revealed no evidence of a hospital record or hospital discharge summary from 7/05/2025. During an interview on 8/13/2025 at 1:24 p.m., LVN B stated she was unable to locate the hospital records for Resident #1 for the 7/05/2025 hospital visit. She stated she was unsure if maybe Resident #1 maybe did not come back with one. LVN B stated normally the resident would come back with hospital records. The nurse would review and contact the physician to let them know the resident had returned to the facility and review a plan of care. LVN B stated the hospital records would then be placed in the basket on the nurses' station desk. She stated the Medical Records staff was responsible for picking up the hospital records from the basket and uploading to the medical record. LVN B stated it was important to have the hospital records available as part of the medical record, so they were available for review. During an interview on 8/14/2025 at 12:16 p.m., Medical Records C (MR C) stated she had not seen any hospital records for Resident #1. She stated if she didn't see a record, she would normally ask the nurses if they got the hospital stuff and they will contact the hospital to get the records. MR C stated she did not notify anyway or even notice the missing hospital records for Resident #1. She stated the facility utilized a white board at the nurses' station to track hospital stays and she had access to review the white board. MR C stated usually a resident who had a hospital visit came back with paperwork and she would have to ask for it several times. MR. C stated she keeps a bin at the nurses' station for documentation and checks and uploads into the computer daily. She stated her turnaround time for uploading was typically same day. She stated the hospital records were important, so the facility knew how to tend and care for the residents. During an interview on 8/14/2025 at 1:12 p.m., the DON stated LVN A was not responding to her calls or requests for interview and was unavailable. The DON stated Resident #1 was sent to the hospital per family request on 7/05/2025. She stated the resident was only gone for a short amount of time, she thought only a couple of hours and then returned to the facility without any orders. The DON stated LVN A documented in PCC(Point Click Care) there were no new orders. She stated this information was obtained by telephone conversation from the hospital to the nurse. The DON stated as an industry they were experiencing the hospital sending resident back to the nursing facilities without any paperwork or documentation. She stated the facility process was for the resident's physician to evaluate the resident within a few days of returning from the hospital. She stated they were not requesting records from the hospital. The DON stated they are only taking verbal information from the hospital. The DON stated she believed the facility was providing continuity of care because the physicians were following up within a few days. She stated she was unsure what the facility policy was for obtaining and retaining hospital records. She stated typically the medical records person was responsible for uploading any records into the computer. Record review of a facility policy, titled Maintenance of Medical Records dated 2023 revealed: This facility will maintain clinical records for each resident in accordance with acceptable standards of practice that reflects the current plan of care and services provided as well as in a manageable size for use by the care providers. 2. In accordance with accepted professional standards of practices, the facility must maintain medical