

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455742	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER The Lev at San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on observation, interview and record review, the facility failed to ensure a registered nurse was designated to serve as the director of nursing on a full-time basis for 1 of 1 facility reviewed for nursing services. The facility failed to ensure a registered nurse was designated as the DON beginning June 15, 2026. This failure could lead to decreased quality of care for residents. Findings included: Record review of the facility staff roster, undated/ reviewed 7/22/2026, did not reflect a staff member designed as DON. During an interview and observation on 7/21/26 at 8:30 AM, the ADM stated the facility did not have a DON and the ADON assumed the duties of the DON until a new DON was hired. The Administrator did not state who was acting as a DON given the ADON's licensure was that of an LVN. Observation of the facility revealed that there was one RN present. During interview on 7/23/2026 at 3:00 PM, the ADON said the previous DON had resigned from the position on 6/15/2026, and there had not been an RN covering the position in the interim. She said the regional [NAME] President of Operations was assisting the facility, but that person was not a registered nurse. During interview on 7/24/2026 at 9:24 AM, the ADM said their regional DON position was currently vacant, the RNs at the facility were not interested in leadership positions, and so there was not a person available to serve at the facility as the DON. She said the facility had hired a new DON who would be starting in August 2026. She said the facility did not have a policy regarding the DON position.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 455742
		If continuation sheet Page 1 of 8

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 residents who use psychotropic drugs receive gradual dose reductions in an effort to discontinue these drugs for 2 of 5 residents (Resident #1 and Resident #2) reviewed for psychotropic medications. The facility failed to show evidence that a GDR had been attempted unless clinically contraindicated for Residents #1's clonazepam [a medication used to treat anxiety] and Resident #2's citalopram [a medication used to treat depression]. These failures could result in unintended effects of medications for residents. Findings included: Record review of Resident #1's admission Record dated 7/22/2026 reflected a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included generalized anxiety disorder [negative feelings of worry or stress that hinder daily life]. Record review of Resident #1's annual MDS dated [DATE] reflected a BIMS score of 14, which indicated intact cognition. Section E of the MDS reflected no negative behaviors were exhibited by Resident #1 during the assessment period. Record review of Resident #1's Care Plan Report undated/ printed 7/22/2026, did not reveal care planning related to previous or future GDR attempts. Record review of Resident #1's Order Summary Report dated 7/22/2026 reflected the following order dated 7/15/2026: Clonazepam [sic] Tablet 0.5 MG Give 1 tablet by mouth three times a day for convulsants [sic] [causing seizures] Record review of the facility document titled Consultant Pharmacist/ Physician Communication dated 4/16/2026 reflected the following: Resident is receiving the following psychoactive medications that are due for review. Per CMS regulations, please evaluate resident for trial dose reduction. Current order: clonazepam 0.5mg TID Proposed change: clonazepam 0.25mg TID If dose reduction is contraindicated or resident failed a previous reduction, please document below. At the bottom of the document, the box checked other with the statement psych [sic] follows and manages meds was handwritten with an undated, illegible signature. Resident #1 was hospitalized during survey and therefore unavailable for interviews attempted on 7/23/2026 and 7/24/2026. Record review of Resident #2's admission Record dated 7/22/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included major depressive disorder, recurrent, moderate [persistent feelings of sadness or hopelessness that interfere with daily life]. Record review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS score of 99, which indicated the assessment could not be performed due to cognitive decline. Record review of Resident #2's Care Plan Report undated/ printed 7/22/2026, did not reveal care planning related to previous or future GDR attempts. Record review of Resident #2's Order Summary Report dated 7/22/2026 reflected the following order dated 6/17/2026: Citalopram Hydrobromide Oral Tablet 10mg Give 3 tablet by mouth one time a day related to DEPRESSION, UNSPECIFIED [sic]. Give 3 tablets to equal 30mg Record review of the facility document titled Consultant Pharmacist/ Physician Communication dated 4/16/2026 reflected the following: Resident is receiving the following psychoactive medications that are due for review. Per CMS regulations, please evaluate resident for trial dose reduction. Current order: citalopram 20mg QD Proposed change: citalopram 10mg QD If dose reduction is contraindicated or resident failed a previous reduction, please document below. At the bottom of the document, the box checked other with the statement psych [sic] follows and manages meds was handwritten with an undated, illegible signature. Resident #2 was unable to participate in an interview attempted on 7/22/2026 at 1:43 PM due to cognitive and communication deficits. In an interview on 7/23/2026 at 9:20 AM, the RPh said she did not have documentation for the GDR recommendations she made for Resident #1 and #2 (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	beyond the documentation of other- psych follows and manages meds. She said she had requested follow-up documentation from facility, but they had not provided any. She said she had also requested contact information for the psychiatry provider so that she may send GDR recommendations directly, but she had not been given that information. She was unsure which staff member she had requested this information from but thought it may have been the DON. In an interview with NP A on 7/23/2026 at 1:55 PM, he said he was the psychiatry provider for Residents #1 and #2. He was unsure if he had completed documentation regarding the GDR recommendations for Residents #1 and #2. He said he felt neither resident would have benefitted from a dose reduction in April 2026, but he was unsure if it had been documented. He said he reviewed the GDR recommendations with the facility and would document directly on the forms if he agreed/disagreed and any additional clinical rationale, so if he had not documented on the forms for Resident #1 or #2, then he likely had not been notified that they were due for a GDR evaluation. In an interview with the ADON on 7/23/2026 at 3:00 PM, she said the GDR reviews for Resident #1 and #2 in April 2026 were reviewed by the former DON. She said the facility performs quarterly reviews of all residents' medications due for GDRs, and the documentation was submitted to the pharmacist and kept on record. She said the facility's medical director often defers to psychiatry for recommendations regarding GDR, and the facility follows up. She was unable to provide documentation regarding the April 2026 GDR recommendation for Resident #2. Record review of the documentation provided by the ADON reflected a progress note for Resident #1 dated 4/02/2026 by NP A that read as follows: .however she reports having been visited by her PCP and pain is to be addressed. she [sic] reports feeling optimistic about this and declines adjustment to psychotropic regimen at this time. no [sic] additional needs concerns [sic] or complaints communicated presently . The ADON said during the same interview she was unsure if this information regarding Resident #1 had been communicated to the pharmacist. She was unsure if a residents' decision about GDR timing was sufficient rationale to decline a GDR attempt. Record review of the facility policy titled Use of Psychotropic Medication dated 2022 reflected the following: .6. Residents who use psychotropic drugs shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs .		

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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 ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 of 5 (Resident #4) residents reviewed for resident rights: The facility failed to have Resident #4's call within reach while he was in bed. This failure could affect residents who use their call light or desire to use the call light and place them at risk of not being able to notify staff of their needs. The findings included: Record review of Resident #4's face sheet, dated 7/24/26 reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included: dysarthria (motor speech disorder) following cerebral infarction (stroke) (primary), respiratory failure, memory deficit, metabolic encephalopathy (brain dysfunction), hypertension, heart failure, kidney disease, and dementia. The RP was listed as: self. Record review of Resident #4's quarterly MDS, dated [DATE], reflected a BIMS score of 9, indicative of moderate impairment in cognition. The ADLs for: B/B were listed as always incontinent. Transfer was listed as dependent while Mobility was listed as substantial/maximal. Toileting was dependent; eating was dependent; and personal hygiene was substantial/maximal. ROM was no impairment. Assistive device was a W/C. Record review of Resident #4's CP, undated, revealed the goal of ADLs with assistance ranging from supervision to substantial/maximal. During an observation and interview on 7/24/26 at 9:02 a.m., Resident #4 was in bed finishing his breakfast meal. The resident was alert and oriented to self. Observation revealed the resident's call light was not in reach of the resident and was situated on the floor under the bed. The resident stated that staff would respond to the lights, and he would also scream for help. The resident stated he could not find his call light. The resident stated he needed the call light because he hurts sometimes and used the call light to get his medications. The Resident added he needed the call light because he poops [bowel movement]. The resident stated on average it took 15-20 minutes for staff to respond to the call light. The resident stated he saw a nursing staff an hour ago (around 8:00 a.m.) that morning for breakfast tray delivery. During an interview on 7/24/26 at 9:18 a.m., CNA E stated he saw the Resident #4 around 7:30 a.m. and the call light was in place. CNA E stated the resident needed a call light in reach to ask for assistance. CNA E stated the resident did use his call light for medications administration, ADLs, and when in pain. CNA E stated when staff did not respond to the call light the resident yelled. CNA E stated the call light might have fallen when resident's bed was raised to a 45-degree angle allowing the call light to fall and staff present not checking before they left during the breakfast tray delivery. During an interview on 7/24/26 at 9:25 a.m., LVN F confirmed that the resident's pressure release call light was on the floor. LVN F stated the call light being on the floor denied the resident the right to request help. LVN F stated she did not notice the call light on the floor when she made rounds about 7:00 a.m., that morning (7/24/26). LVN F stated the call light might have fallen on the floor when staff sat up the resident for breakfast meal and did not realize the call light might have fallen. LVN F stated her expectation when nursing staff provided a meal to the resident was that they check on the placement of the call light before leaving the room. LVN F stated residents were kept safe through monitoring and rounds, and the checking of call light within reach. During an interview on 7/24/26 at 9:40 a.m., the ADON stated she had no explanation why the call light was on the floor involving Resident #4. The ADON stated her expectation was that a call light was in reach of residents because the call light allowed the resident to call for assistance. The ADON stated what should have happened through rounding or after leaving the resident's room (Resident #4) (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was that the staff should have checked on the placement of the call light. During an interview on 7/24/26 at 10:00 a.m., CNA G stated she recalled that on 3/21/26 [date is correct] she responded to a call light from Resident #4 where his roommate, Resident #5, threw a trash can at him. CNA G stated Resident #4 could use the call light to ask for assistance as evidenced by him using the call light on 3/21/26 for an alleged act of abuse. CNA G stated the call light needed to be in reach of Resident #4 because he was confused at times. During an interview on 7/24/26 at 11:14 a.m., the Administrator stated regarding Resident #4's call light observed on the floor, the staff were trained to round on the call lights, and she had no explanation for the call light being on the floor. The Administrator stated that the call light needed be within reach of a resident because that is how they communicate to get assistance. Record review of facility's Call Lights: Accessibility and Timely Response policy, dated 20222, read Staff will ensure the call light is within reach of resident and secured as needed.		

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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** Based on interview and record review, the facility failed to ensure 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 2 of five residents (Resident #1 and Resident #2) reviewed for pharmacy services. The facility failed to ensure the indication for Resident #1's medication, clonazepam, was ordered for the accurate, intended diagnosis. The facility failed to ensure the indication for Resident #2's medication, finasteride, was ordered for the accurate, intended diagnosis. These failures could lead to improper monitoring of the therapeutic effects of residents' medications. Findings included: 1. Record review of Resident #1's admission Record dated 7/22/2026 reflected a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included generalized anxiety disorder [negative feelings of worry or stress that hinder daily life]. Record review of Resident #1's annual MDS dated [DATE] reflected a BIMS score of 14, which indicated intact cognition. Section E of the MDS reflected no negative behaviors were exhibited by Resident #1 during the assessment period. Record review of Resident #1's Order Summary Report dated 7/22/2026 reflected the following order dated 7/15/2026: Clonazepam [sic] Tablet 0.5 MG Give 1 tablet by mouth three times a day for convulsants [sic] [causing seizures] Record review of Resident #1's July 2026 MAR, dated 7/22/2026 reflected Resident #1 had received the clonazepam in July 2026, as ordered. Record review Resident #1's progress notes revealed documentation from NP A dated 6/18/2026 which indicated Resident #1 was prescribed clonazepam 0.5 mg three times a day for anxiety. In an interview on 7/23/2026 at 9:20 AM, the RPh said her records reflected Resident #1 was prescribed clonazepam for anxiety. She said she was unable to view the facility's records related to Resident #1's prescriptions due to technical issues, but she did not have any records indicating Resident #1 had a history of seizures. She said she reviewed the medication regimens for all residents at the facility on a monthly basis, she had not seen a clonazepam order for Resident #1 with a documented indication of convulsants. In an interview with NP A on 7/23/2026 at 1:55 PM, he said Resident #1 was prescribed clonazepam for anxiety, and she had been taking the medication since before he was responsible for her care. In an interview with the ADON on 7/23/2026 at 3:00 PM, she said Resident #1 was prescribed clonazepam for anxiety, and she was unsure why the order was entered with an indication for convulsants. She said the orders entered by nursing staff were reviewed during the facility's morning meeting to ensure the accuracy of the orders, and she was unsure how this order had not been noticed and corrected. She said having incorrect indications for medications could lead to improper monitoring of the effects of the medications. 2. Record review of Resident #2's admission Record dated 7/22/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included need for assistance with personal care. Record review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS score of 99, which indicated the assessment could not be performed due to cognitive decline. Record review of Resident #2's Order Summary Report dated 7/22/2026 reflected the following order dated 3/26/2026: Finasteride 5 MG Tablet Give 1 tablet by mouth one time a day for GENITOURINARY AGENTS [sic] females of childbearing age should not touch or handle crushed or broken tablets Record review of Resident #2's July 2026 MAR dated 7/22/2026 reflected he had been received the finasteride as ordered. In an interview with the RPh on 7/23/2026 at 9:20 AM, she said she reviewed the medication regimens for all residents at the facility on a monthly basis. She said she was unable to view the facility's records (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	related to Resident #2's prescriptions during the interview due to technical issues, but genitourinary agents was not a proper indication for a medication because the term described the medication class and not the reason Resident #2 required the medication. In an interview with the ADON on 7/23/2026 at 3:00 PM, she said Resident #2 was prescribed finasteride due to urinary issues relating to an enlarged prostate (physical obstruction making urination difficult). She said the orders entered by nursing staff are reviewed during the facility's morning meeting to ensure the accuracy of the orders, and she was unsure how this order had not been noticed and corrected. She said having incorrect indications for medications could lead to improper monitoring of the effects of the medications. Record review of the facility policy titled Use of Psychotropic Medication dated 2022 reflected the following: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record .		

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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 help prevent the development and transmission of communicable diseases and infections for 1 of 5 residents (Resident #6) reviewed for infection prevention. The facility failed to ensure staff utilized proper infection control practices, including PPE, when providing care for Resident #6. This failure could lead to the spread of infection and illness. Findings included: Record review of Resident #6's admission Record dated 7/22/2026 reflected a [AGE] year-old male admitted to the facility on [DATE]. Diagnoses included dependence on renal dialysis (when the body requires artificial filtering of the blood). Record review of Resident #6's quarterly MDS dated [DATE] reflected a BIMS score of 13, which indicated intact cognition. Section O0100 J1. of the MDS reflected Resident #6 required dialysis treatments, and section O0100 O1 (IV access) was not assessed. Record review of Resident #6's Order Summary Report dated 7/22/2026 reflected the following order dated 6/15/2026: Resident is on Enhanced Barrier Precautions r/t dialysis port: Use gown and gloves for high-contact resident care. May use face shield as needed if there is risk for splash or spray. every shift [NAME] gloves and gown before high contact resident care. Remove gown and gloves and handwash/sanitize hands, before exiting the room or before providing care to another resident in the room. In an observation and interview on 7/22/2026 at 1:40 PM, CNA B was observed providing incontinent care to Resident #6. CNA B was not wearing a gown while performing the procedure. Resident #6's exterior door did not have signage that indicated Resident #6 required EBP. CNA B initially said Resident #6 did not require EBP, as evidenced by the lack of signage. She then said Resident #6 had a dialysis catheter on his chest and did require EBP, and he should have a sign on his door indicating the precautions. She said she should have worn a gown as well as gloves when providing the care, and the failure to do so could lead to the spread of infection. She said she had received training regarding infection prevention but had forgotten to use proper PPE because the sign had somehow been misplaced. In an interview on 7/22/2026 at 1:45 PM, LVN C said Resident #6 required EBP. She was unsure where the sign indicating the EBP was, and she said it had been there previously. In an interview with the ADON on 7/23/2026 at 3:00 PM, she said she served as the facility's Infection Preventionist, and the facility expectation was resident's requiring EBP would have proper signage. She said staff are expected to follow guidelines for PPE and had all received training. Record review of the facility policy titled Enhanced Barrier Precautions dated 2022, reflected the following: .c. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves .4. High-contact resident care activities include: .d. Providing hygiene .f. Changing briefs or assisting with toileting .		