

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

Printed: 11/21/2025
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 09/11/2025
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure each resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility and each resident was treated with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality, for 2 of 16 residents (Resident #77 and Resident #32) reviewed for a dignified existence. CNA D, who was bilingual and CNA E, who only spoke Spanish, provided incontinent care for Resident #77 while only speaking Spanish although Resident #77 could not understand Spanish and felt disrespected and demoralized. LVN B and LVN H failed to take action when Resident #32 reported a change in condition which resulted in Resident #32 questioning whether she mattered. These deficient practices could place residents at risk for feeling unworthy and for an undignified existence. The findings included: 1. A record review of Resident #77's admission record dated [DATE] revealed an admission date of [DATE] with diagnoses which included complete quadriplegia (a severe spinal cord injury that results in the complete loss of motor and sensory function below the neck), major depressive disorder, and bipolar disorder (a mental health condition characterized by significant and persistent shifts in mood, energy, and behavior between periods of highs and extreme lows.) A record review of Resident #77's quarterly MDS assessment dated [DATE] revealed Resident #77 was a [AGE] year-old female admitted for LTC and assessed with a BIMS score of 15 out of a possible 15 which indicated no cognitive impairment. A mood assessment revealed Resident #77 had experienced some episodes of feeling down, depressed, and hopeless and feelings of isolation and loneliness over the review period [DATE]. Further review revealed Resident #77 was assessed as requiring assistance with her needs for "Activities of Daily Living" (ADL), "dependent" - helper does all of the effort. Resident does none of the effort to complete the activity. A record review of Resident #77's care plan dated [DATE] revealed, "(Resident #77) is dependent on staff for meeting emotional, intellectual, physical, and social needs related to quadriplegia. &hellip; all staff to converse with resident while providing care. &hellip; (Resident #77) has an ADL self-care performance deficit related to quadriplegia &hellip; the resident is totally dependent on one or two staff per personal hygiene all care." (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on [DATE] at 11:18 AM revealed Resident #77 in her room and in her bed. Resident #77 stated she was a quadriplegic and could not move herself other than use her head and speak. Resident #77 stated she was dependent on staff for all her needs and felt disrespected and ignored when staff would not communicate with her in English. Resident #77 stated she only spoke English and could not understand Spanish. Resident #77 stated many of the facility's staff only spoke Spanish and the language barrier was a significant detriment to her ability to ask for help or to request specific needs. Resident #77 stated she could not communicate with staff regarding the quality of incontinent care and specified she felt the staff had not thoroughly cleaned her with incontinent care. Resident #77 stated when she would attempt to communicate her wishes Spanish Speaking staff would often assume, incorrectly, what she meant. Resident #77 stated she felt frustrated when the language barrier produced events where staff would stare at her with a grin while not comprehending her wants and needs. Resident #77 stated how frustrating and demoralizing the experience when all she could do is speak and no one could understand her; simple tasks such as enjoying a meal, a drink, being comfortable and clean became unpleasant experiences. During an observation and interview on [DATE] at 2:21 PM revealed Resident #77 in bed requesting incontinent care. CNA D and CNA E entered Resident #77 room and began organizing Resident #77's room for incontinent care which included sanitization of the bedside table, preparing supplies, and providing privacy. CNA D greeted Resident #77 in English and CNA E greeted Resident #77 in Spanish. Observation of the incontinent care revealed CNA D and CNA E conversed with each other in Spanish and had not translated their conversation to Resident #77. Resident #77 throughout the care experience had addressed the CNAs regarding details of the care they were providing and CNA E responded to Resident #77 in Spanish. Resident #77 stated the experience was frustrating but not uncommon. During an interview on [DATE] at 2:40 PM with CNA D and CNA E, CNA E stated she could understand some English but could not speak English and CNA D stated she was bilingual and recognized CNA E could not understand details in English. CNAs D and E agreed they had provided care for Resident #77 and conversed with each other in Spanish and had not translated any of the conversation to Resident #77. During an interview on [DATE] at 3:20 PM LVN F stated she was the nurse for Resident #77 and supervised CNA D and E at times. LVN F stated Resident #77 only spoke English and was not aware if Resident #77 could understand Spanish. LVN F stated she believed CNA E could understand some English and expected CNAs to speak to residents in English. LVN F stated she was unaware CNA D and E provided care to Resident #77 while speaking Spanish and not translating the communication with Resident #77. During an interview on [DATE] at 5:10 PM the DON stated the expectation was for staff to provided dignified care to residents while communicating in a language the residents could understand and for staff to understand residents wants and needs which were expressed in English. The DON stated a language barrier could contribute to Residents' frustration and demoralization. During an interview on [DATE] at 6:00 PM the Administrator stated she concurred with the DON and would address the language barrier between the staff and residents and would bring the problem to the QAPI committee. A record review of the facility's undated policy titled, "Resident Rights" revealed, "when residents' knowledge of English or the predominant language of the facility is inadequate for comprehension, a means to communicate the information concerning rights and responsibilities in a language familiar to the resident will be made available and implemented &hellip;." (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #32's face sheet, dated [DATE], revealed she was admitted to the facility on [DATE] with diagnoses including Cardiomyopathy, unspecified (a disease of the heart muscle. It causes the heart to have a harder time pumping blood to the rest of the body, which can lead to symptoms of heart failure) and Type 2 Diabetes Mellitus (condition that occurs when the body develops insulin resistance and no longer responds effectively to insulin) with diabetic polyneuropathy (occurs when there is damage to multiple nerves in the peripheral nervous system in different parts of the body at the same time. Peripheral nerves are the nerves outside the brain and spinal cord). Review of Resident #32's quarterly MDS assessment, dated [DATE], revealed her BIMS score was 10 of 15 reflective of moderate cognitive impairment, she had history of Diabetes Mellitus and Cardiomyopathy. Review of Resident #32's Care Plan, revised [DATE], revealed she had Diabetes Mellitus, interventions included Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Further review revealed Resident #32 was at risk for acute pain and has chronic pain r/t Diabetic Polyneuropathy and interventions included Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Review of Resident #32's progress notes from [DATE] to [DATE] revealed there were no nurse's progress noted entered related to Resident #32 reporting numbness to her left arm, left leg and having chest pain Interview on [DATE] at 1:05 PM with Resident #32 revealed her left arm and left leg felt completely numb a couple of times in the last couple of weeks. She stated she also felt a sharp pain on her chest (she put her left hand over her heart). She stated she reported her symptoms to a day nurse and a night nurse. Resident #32 stated she did not remember their names. She stated one night she rubbed and massaged her arm until it felt better. She stated she had not heard anything back from the nursing staff. Resident #32 stated a female doctor came by but only ordered labs. Resident #32 commented, I know I'm old and I'm going to die maybe that's why the nurse's haven't done anything. I don't know what's going on. Resident #32 stated she felt sad because she was worried about her health. Interview on [DATE] at 4:37 PM with the DON revealed that nursing staff had not reported Resident #32's change of condition, her reported concerns regarding her having numbness to her left arm, left leg or having chest pain. She stated she imagined Resident #32 felt like she was not important and did not feel good about the fact that nursing staff had not taken any action. The DON stated It was important that nursing staff completed a change of condition form, document a progress note, assess the resident, report it to the MD/NP and follow any new orders so the resident received the care and services as needed. The DON stated failure to do so could jeopardize the resident's health and in Resident #32's case she expected nursing staff to send her out via 911. The DON stated Resident #32 could have had a heart attack and died. The DON stated nursing staff should also report any changes to her and or the ADON, so everyone was aware of the changes and there was a continuity of care for Resident #32. Review of the facility's undated policy titled, "Resident Rights", undated, revealed in relevant part Respect and dignity. The resident has a right to be treated with respect and dignity.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had the right to make choices about aspects of his or her life in the facility for 1 of 8 (Resident #4) reviewed for resident rights. Resident #4 was not informed of the care being provided to her regarding a cut on her face received during a surgical procedure. These failures could place residents at risk of not having choices regarding treatment. Record review of Resident #4's admission Record, dated 09/12/2025, reflected that Resident #4 was initially admitted on [DATE] with diagnoses of schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors). Record review of Resident #4's Diagnosis Report, dated 09/12/2025, reflected that Resident #4 was diagnosed with schizoaffective disorder, depressive type on 04/03/2025, and bipolar disorder on 12/03/2024. Record review of Resident #4's Quarterly MDS Assessment, dated 06/17/2025, reflected that Resident #4 had a BIMS score of 14, indicating intact cognition. Further review reflected that Resident #4 had diagnoses of anxiety disorder, depression, bipolar disorder, and schizophrenia. Record review of Resident #4's Comprehensive Person-Centered Care Plan, dated 09/09/2025, reflected, [Resident #4] uses psychotropic medications r/t schizoaffective disorder depressed type initiated on 05/29/2025, and [Resident #4] has a mood problem r/t mood disorder due to known physiological condition with depressive features, bipolar disorder, anxiety disorder initiated on 02/26/2025. Record review of Resident #4's Skin Assessment, dated 09/07/2025, reflected that the Wound Care Nurse had assessed Resident #4 with a cut on the right side of her cheek with no new orders. Interview on 09/08/2025 at 10:25 AM, Resident #4 stated that somehow, she got a cut on her cheek, about an inch, next to her nose, during a surgery the week prior. Resident #4 stated that a nurse looked at it but has not told her the plan of care. Resident #4 stated that she preferred to have some sort of ointment for the cut since it is on such a prominent area of her face. Resident #4 stated she told the nurse she was concerned about the cut scarring. Interview on 09/10/2025 at 9:35 AM, the Wound Care Nurse stated that she did a skin assessment for Resident #4 at which time, Resident #4 had voiced concern for the cut on her face. The Wound Care Nurse stated she had told Resident #4's physician of the cut on her face and that there were no new orders. The Wound Care Nurse stated she had not talked to Resident #4 about no new orders for the laceration on her face. Interview on 09/11/2025 at 4:37 PM, the DON stated her expectation is to complete a risk management injury of unknown origin form, which would prompt staff to follow-up with notifying the physician/NP, RP, and to detail the treatments and/or monitoring. The DON stated she was told by the Wound Care Nurse that she was not informed of Resident #4's laceration to her face because it's a scab. The DON stated that scarring could be a negative outcome of not informing residents of treatment options when lacerations occur. Record review of facility policy, undated, titled, Resident Rights reflected, The resident has the right to be informed of, and participate in, his or her treatment, including: .d. The right to be informed by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the latervative or option he or she prefers.		

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations, interviews, and record reviews the facility failed to post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility for 1 of 3 years of recertification surveys (2024) for survey results reviewed. The facility posted the results for annual recertification survey for 2023 and omitted the most recent survey results from 2024. This failure could deny residents, Resident representatives, and the public from examining the most recent survey results. The findings included: During an observation and record review on 9/7/2025 at 3:50 PM revealed the facility's survey results binder by the receptionist desk in the facility's public common area. the survey results binder was kept in a wall mounted binder holder. The binder contained results from previous surveys with the latest date of 2/16/2024. A record review of the Texas Unified Licensure Information Portal (TULIP) website accessed 9/7/2025 revealed the last recertification survey for the facility was 8/30/2024. During an interview on 9/11/2025 at 5:00 PM the Administrator stated it was their policy to ensure the most recent survey results were kept in the binder and made public. The Administrator stated the binder with the most recent survey results was kept in a binder on the wall by the receptionist desk in the facility's public lobby. The Administrator stated it was her responsibility to ensure the results of the most recent survey were kept in the binder and stated the most recent survey results were from August 2024. The Administrator stated she was unaware the results were not in the binder. The administrator stated the potential negative outcome could be that Residents, Resident representatives, and the public would be denied examining the most recent survey results. A policy was requested, and the Administrator stated the facility followed HHSC guidelines.		

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)		

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 1 of 1 facility reviewed for safe and clean environment clean medication-cart wheels. The facility failed to maintain the floors free from seeping adhesive glue used to secure the flooring and causing the wheels of the medication carts to become matted with hair and debris. This failure could place residents at risk for dirty floors and wheeled equipment. The findings included: A record review of Resident #68's admission record dated 9/11/2025 revealed an admission date of 10/18/2023 with diagnoses which included acquired absence of both right and left legs, type II diabetes (a disease which results in the body's cells inability to utilize blood sugars and thus high levels of blood sugars produce negative effects), and chronic obstructive pulmonary disease (a group of long-term lung conditions such as emphysema and chronic bronchitis which cause shortness of breath, coughs that gets worse and could affect daily activities over time.) A record review of Resident #68's quarterly MDS assessment dated [DATE] revealed Resident #68 was a [AGE] year-old male admitted for LTC and assessed with a BIMS score of 14 out of a possible 15 which indicated no impairment of cognition. Further review revealed Resident #68 was assessed with adequate vision, hearing, and could make himself understood and could understand others. Resident #68 was assessed with the need of a wheelchair for ambulation. A record review of the facility's letter from the flooring contractor dated 9/12/2025 revealed, Subject: Flooring Concerns; To whom it may concern, We have had several issues with the flooring at the above location due to the glue sent to us by the manufacture of the floor. (Contractor) has been out to try to rectify the issue and has been in contact with the flooring company and the community throughout this process. - June 19, 2024, (Contractor) was on site to relay the flooring due to having issues with the glue used for the flooring. - September 24, 2024, crew came in with a floor cleaning and buffing machine, closed any gaps from the deep clean, and set glue on areas coming up, left marked with painter's tape. - October 14, 2024, crew sent to continue working on spot checking floors, scraping up painter's tape and assessing areas that were glued once more from last visit. - November 14, 2024, the office manager met with facility crew to look at the issue. - July 10, 2025, met with (facility Maintenance Director) to round on glue replacement, found that previous attempts were not successful, discussed other glue options used internally by the community in the BOM office. - July 19, 2025, crew sent to remove sections of flooring, clean and reinstall with different manufacturer glue. - August 14, 2025, met with (the Administrator) to discuss a plan to make repairs. - September 8, 2025, spoke to (the Administrator) again about what could be done due to the glue not adhering and leaking out the edges of the flooring. Tentative plan to remove all flooring and replace with new glue, pending scheduling arrangements. We have been in contact with the warranty department for the flooring and it has been determined to be an issue with the glue itself. Sincerely, CEO (Contractor). During daily observation from 9/8/2025 through 9/11/2025 revealed the facility's floors were dirty with glue seeping from the tiles / planks. During daily observation from 9/8/2025 through 9/11/2025 revealed the facility's medication-carts wheels were clogged with matted hair and debris. During an observation and interview on 9/11/2025 at 11:34 AM with the facility's Housekeeping Director (HK Director) and Resident #68; the HK Director stated the floors were dirty with the glue which was used by the flooring contractor which has continued weeping up from under the floor and gums up the floor. The HK Director stated she and the maintenance director had attempted to clean and mop the floors but could not contain the flooring glue from weeping / oozing out and acting like gum collecting dirt. The HK stated she would assign staff to assist the maintenance director with attempts to scrape up the glue monthly. The HK director stated the flooring had been weeping glue since the flooring was installed about a year ago. Resident #68 agreed and stated, they need to get a solvent and clean it up or replace the floor with a good sealant. Resident #68 stated the floors were sticky and collected hair and trash which stuck to his wheelchair and would get on his hands as he used his hands to grab the wheels and propel himself. During an interview on 9/11/2025 at 5:00 PM the Administrator stated the flooring contractor had used a faulty ineffective flooring adhesive which had seeped out from underneath the tiles. The Administrator stated she had been coordinating with the flooring contractor since 2024 to remedy the seeping glue and was ready to coordinate a time and space to begin replacing the flooring. The Administrator stated the potential negative effect to residents could place residents at risk for dirty floors and wheeled equipment. A policy was requested, and the Administrator stated		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)		

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F 0585 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 observations, interviews, and record reviews the facility failed to ensure residents had the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which had been furnished as well as that which had not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay, for 1 of 8 residents (Resident #77) reviewed for making a grievance. Resident #77 made a grievance to CNA D that she no longer wished for CNA E to provide care for her and CNA D did not initiate a grievance report nor did she report Resident #77's grievance to anyone. This failure could place residents at risk for not having their grievances heard and or resolved. The findings included: A record review of Resident #77's admission record dated 9/10/2025 revealed an admission date of 1/9/2023 with diagnoses which included complete quadriplegia (a severe spinal cord injury that results in the complete loss of motor and sensory function below the neck), major depressive disorder, and bipolar disorder (a mental health condition characterized by significant and persistent shifts in mood, energy, and behavior between periods of highs and extreme lows.) A record review of Resident #77's quarterly MDS assessment dated [DATE] revealed Resident #77 was a [AGE] year-old female admitted for LTC and assessed with a BIMS score of 15 out of a possible 15 which indicated no cognitive impairment. A mood assessment revealed Resident #77 had experienced some episodes of feeling down, depressed, and hopeless and feelings of isolation and loneliness over the review period August 2025. Further review revealed Resident #77 was assessed as requiring assistance with her needs for Activities of Daily Living (ADL), dependent - helper does all of the effort. Resident does none of the effort to complete the activity. A record review of Resident #77's care plan dated 9/10/2025 revealed, (Resident #77) is dependent on staff for meeting emotional, intellectual, physical, and social needs related to quadriplegia. all staff to converse with resident while providing care. (Resident #77) has an ADL self-care performance deficit related to quadriplegia . the resident is totally dependent on one or two staff per personal hygiene all care. During an observation and interview on 9/07/2025 at 11:18 AM Resident #77 revealed Resident #77 in her room and in her bed. Resident #77 stated she was a quadriplegic and could not move herself other than use her head and speak. Resident #77 stated she was dependent on staff for all her needs and felt disrespected and ignored when staff would not communicate with her in English. Resident #77 stated she only spoke English and could not understand Spanish. Resident #77 stated many of the facility's staff only spoke Spanish and the language barrier was a significant detriment to her ability to ask for help or to request specific needs. Resident #77 stated she could not communicate with staff regarding the quality of incontinent care and specified she felt the staff had not thoroughly cleaned her with incontinent care. Resident #77 stated when she would attempt to communicate her wishes Spanish Speaking staff would often assume, incorrectly, what she meant. Resident #77 stated she felt frustrated when the language barrier produced events where staff would stare at her with a grin while not comprehending her wants and needs. Resident #77 stated how frustrating and demoralizing the experience when all she could do is speak and no one could understand her; simple tasks such as enjoying a meal, a drink, being comfortable and clean became unpleasant experiences. Resident #77 stated she had reported this grievance to staff which included CNA D and included her wish to not have CNA E provide care for her anymore. During an interview on 9/8/2025 at 2:40 PM with CNA D stated she had received a grievance from Resident #77 in the afternoon of 9/7/2025 which included she no longer wished for CNA E to provide care for her due to CNA E's inability to speak and or understand English. CNA D stated she had not initiated a grievance report and had not reported the grievance to anyone. During an interview on 9/11/2025 at 3:20 PM LVN F stated she was the nurse for Resident #77 and supervised CNA D. LVN F stated Resident #77 only spoke English and was not aware if Resident #77 could understand Spanish. LVN F stated she believed CNA E could understand some English and expected CNAs to speak to residents in English. LVN F stated she was unaware CNA D had received a grievance from Resident #77 and would expect for staff to report grievances and to initiate a grievance report. During an interview on 9/11/2025 at 5:10 PM the DON stated the expectation was for staff to assist residents to initiate grievance reports whenever the staff receive a grievance. The DON stated CNA D had reported she had not initiated Resident #77 grievance on 9/7/2025 and on 9/8/2025 CNA D assisted Resident #77 to document a grievance report. The DON stated the grievance was reported to the		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) program for residents with newly evident or possible serious mental disorder for 1 of 8 Residents (Resident #6) whose records were reviewed related to PASARR screenings. The facility failed to refer Resident #6 for Level I screening after being diagnosed with a mental disorder. This failure could place residents with new mental diagnoses at risk for not receiving services as identified by PASARR. The findings included: Record review of Resident #6's admission Record, dated 09/11/2025, reflected that Resident #6 was initially admitted on [DATE] with diagnoses of Bipolar II Disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), end stage renal disease (condition in which the kidneys lose the ability to remove waste and balance fluids), and type 2 diabetes mellitus. Record review of Resident #6's Diagnosis Report, dated 09/11/2025, reflected that Resident #6 was diagnosed with Bipolar II Disorder on 04/10/2025. Record review of Resident #6's Quarterly MDS Assessment, dated 06/11/2025, reflected that Resident #6 had a BIMS score of 9, indicating moderate cognitive impairment. Further review reflected Resident #6 had a diagnosis of bipolar disorder. Record review of Resident #6's Comprehensive Person-Centered Care Plan, dated 09/10/2025, reflected, [Resident #6] has a mood problem r/t Bipolar disorder initiated on 04/23/2025. Record review of Resident #6's Electronic Health Record reflected that Resident #6 had not had a PASARR since his admission PASARR. PASARR dated 3/31/2025 did not reflect resident had a diagnosis of bipolar disorder and depression. Interview on 09/10/2025 at 10:04 AM, the Social Worker stated that she had recently become the person who oversaw PASARR at the facility. The Social Worker stated she was uncertain if a new PASARR should be done if a new diagnosis is added if they have already had a PASARR assessment that has resulted in a negative initial PASARR screening. Interview on 09/11/2025 at 4:37 PM, the DON stated her expectation was for PASARR screenings to be completed if they receive a new diagnosis. The DON stated that all notes from behavioral health are reviewed by MDS for new diagnoses and staff would be informed by MDS about these new diagnoses. The DON stated that there is the risk for residents to not receive appropriate benefits if they do not get a new PASARR screening after receiving a new diagnosis. Record review of facility policy titled, Resident Assessment - Coordination with PASARR Program, undated, reflected, Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments to reflect the current condition for 1 of 6 residents (Resident #25) reviewed for care plan revisions. The facility failed to ensure Resident #25's care plan was comprehensive and reflected uncontrollable nausea and vomiting during the resident's menstrual cycles. This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs. The findings included:Record review of Resident #25's face sheet, dated 09/11/2025, reflected that Resident #25 was a [AGE] year-old female resident with an initial admission of 10/08/2021 with diagnoses of hypoglycemia (condition in which the body's blood sugar level goes below the standard range), bipolar disorder, and type 2 diabetes mellitus. Record review of Resident #25's Quarterly MDS Assessment, dated 06/09/2025, reflected that Resident #25 had a BIMS score of 11, indicating moderate cognitive impairment. Record review of Resident #25's Comprehensive Person-Centered Care Plan, dated 09/08/2025, did not reflect any information related to Resident #25's menstrual cycle. Interview on 09/08/2025 at 2:05 PM, LVN B stated that Resident #25 has uncontrollable nausea and vomiting while she was on her menstrual cycle most months. Interview on 09/09/2025 at 9:37 AM, NP C stated that Resident #25 had frequent uncontrollable nausea and vomiting while she was on her menstrual cycle most months, and that there is a standing order for Zofran because of it. Interview on 09/11/2025 at 4:37 PM, the DON stated that Resident #25's uncontrollable nausea and vomiting during her menstrual cycle should be on a care plan. The DON stated that if it is not in the care plan the resident has the risk of other staff not being aware of that symptom and could lead to misdiagnosis. A policy on updating care plans was requested on 09/11/2025 at 4:45 PM and was not provided to the survey team prior to exit.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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** Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and the residents choices for 2 of 13 residents (Resident #4 and Resident #32) reviewed for quality of care. 1.Resident #4 did not receive wound care to a laceration on her face after voicing concerns over lack of wound care and potential scarring. 2.LVN B and LVN H failed to act upon Resident #32's change of condition when she reported her left arm and left leg were going numb and having chest pain. These failures could place residents at risk for not receiving appropriate care and treatment and/or a decline in their health. The findings included:2. Review of Resident #32's face sheet, dated [DATE], revealed she was admitted to the facility on [DATE] with diagnoses including Cardiomyopathy, unspecified (a disease of the heart muscle. It causes the heart to have a harder time pumping blood to the rest of the body, which can lead to symptoms of heart failure) and Type 2 Diabetes Mellitus (condition that occurs when the body develops insulin resistance and no longer responds effectively to insulin) with diabetic polyneuropathy (occurs when there is damage to multiple nerves in the peripheral nervous system in different parts of the body at the same time. Peripheral nerves are the nerves outside the brain and spinal cord). Review of Resident #32's quarterly MDS assessment, dated [DATE], revealed her BIMS score was 10 of 15 reflective of moderate cognitive impairment, she had history of Diabetes Mellitus and Cardiomyopathy. Review of Resident #32's Care Plan, revised [DATE], revealed she had Diabetes Mellitus, interventions included Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Further review revealed Resident #32 was at risk for acute pain and has chronic pain r/t Diabetic Polyneuropathy and interventions included Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Review of Resident #32's progress notes from [DATE] to [DATE] revealed there were no nurse's progress noted entered related to Resident #32 reporting numbness to her left arm, left leg and having chest pain Interview on [DATE] at 1:05 PM with Resident #32 revealed her left arm and left leg felt completely numb a couple of times in the last couple of weeks. She stated she also felt a sharp pain on her chest (she put her left hand over her heart). She stated she reported her symptoms to a day nurse and a night nurse. Resident #32 stated she did not remember their names. She stated one night she rubbed and massaged her arm until it felt better. She stated she had not heard anything back from the nursing staff. Resident #32 stated a female doctor came by but only ordered labs. Resident #32 commented, I know I'm old and I'm going to die maybe that's why the nurse's haven't done anything. I don't know what's going on. Resident #32 stated she felt sad because she was worried about her health. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 1:51 PM with LVN H revealed she verbalized her understanding of identifying a resident's change of condition and the facility protocol. She stated a change of condition was a resident experiencing anything out of the ordinary like someone throwing up twice a shift; something that had not happened before. She stated, I would notify the MD, RP, assess the resident and complete a change of condition evaluation in the resident's record. LVN H stated an assessment included taking the resident's vitals. She stated she would report them to the MD. LVN H stated about two weeks ago Resident #32 reported her arm was going numb. She stated Resident #32 told her she met with NP C and NP C ordered labs. LVN H stated she called NP C, confirmed the labs with NP C and she entered the new order for the labs into Resident #32's record. LVN H stated she did not pass the information to the oncoming nurse because she believed NP C had addressed Resident #32's concerns but stated she did not discuss Resident #32's reported concern with NP C. She stated Resident #32 also mentioned she told another nurse so again she believed the Resident's concern had been addressed. LVN H stated she did not look in Resident #32's progress notes to ensure her reported concerns had been addressed. She stated when she assessed Resident #32, she did not see anything out of the ordinary and if she wrote a progress note it would be in Resident #32's electronic record. LVN H stated she did not complete a change of condition, did not write a note in the 24-hour report and did not call the RP. LVN H stated depending on the situation she could let the DON know about it and stated she did not report Resident #32's reported concerns it to the DON. LVN H then stated NP C said Resident #32 told her about the numbing of the arm and that's why she ordered labs. LVN H stated NP C ordered a CBC (Complete Blood Count), CMP (Comprehensive Metabolic Panel) and Magnesium test (the signs of low or high magnesium levels). She stated she did not know the results. Interview on [DATE] at 3:09 PM with NP C revealed she met with Resident #32 on [DATE] during rounds. She stated she met with Resident #32 every time while at the facility because Resident #32 always had something to complain about. She stated Resident #32 did not report numbness to her left arm, left leg and or having chest pains to her. NP C stated nursing staff called her about the labs she ordered for Resident #32 but did not call her to report numbness to Resident #32's left arm, left leg or that she was having chest pains. NP C stated sometimes Resident #32 was not consistent when sharing her concerns but if Resident #32 was experiencing reported symptoms nursing staff should have called her to report Resident's signs and symptoms. NPC stated she would have ordered an EKG ((electrocardiogram) is a quick, non-invasive test that records the electrical activity of your heart to help diagnose various heart conditions) or at the very least would provide nursing staff with an order to administer nitroglycerin (Nitroglycerin is a medication used to treat or prevent chest pain (angina). NP C stated Resident #32 could have had a heart attack or worse, especially if she had a diagnosis of Cardiomyopathy. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 4:03 PM with LVN B revealed she normally worked 2:00 PM to 10:00 PM; the second shift. She stated Resident #32 was able to communicate her needs with staff. LVN B stated she did not remember NP C's last visit, but stated she worked, Saturday, [DATE]. Then, LVN B stated she remembered NP C being at the facility during the early morning hours but did not provide any new orders. LVN B stated, to her, Resident #32 did not look like she was experiencing any changes on [DATE]. She stated Resident #32 mentioned a couple of weeks ago about having numbness to her left arm. She stated she administered 4 units of insulin that same night and Resident #32 complained of pain. She stated she called NP C and NP C scaled the sliding scale insulin back to level 1 on the sliding scale. LVN B stated she thought Resident #32's numbness was related to the pain. She stated Resident #32 said she told another nurse about having numbness, but nursing staff had not said anything to her during report. LVN B stated Resident #32's reported numbness to her left arm was considered to be a change of condition because Resident #32 had never reported numbness before. LVN B stated for a change of condition, she should report it to NP C, write a progress note and report it to the ADON/DON. She stated she would also notify the family. LVN B stated the first thing she would do was assess Resident #32, take vital signs before reporting the findings to NP C and would follow any new orders. LVN B stated she assessed Resident #32 who told her she barely had any feeling to her left arm. LVN B stated she took Resident #32's vitals which were within normal limits but stated she did not document the vitals. LVN B stated it slipped my mind, but again stated, but I completed a full assessment, and her vitals were within normal limits. LVN B stated she should also pass on the information in report so staff would be aware of Resident #32's change of condition and were up to date about Resident #32's concerns. LVN B stated she did not pass the information during report to the on-coming nurse. She stated because she did not tell the on-coming nurse, there was a lag in communication and it was possible there would not be any follow up related to Resident #32's change of condition. LVN B stated Resident #32 could have gotten worse. She stated she woke Resident #32 up once during the night after reporting numbness and Resident #32 said she was feeling better. LVN B stated Resident #32 did not report having chest pain. Interview on [DATE] at 4:37 PM with the DON revealed nursing staff had not reported Resident #32 having numbness to her left arm. She stated she was also not aware that Resident #32 reported numbness to her left leg and had chest pain. The DON stated It was important that nursing staff completed a change of condition form, document a progress note, assess the resident, report it to the MD/NP and follow any new orders so the resident received the care and services as needed. The DON stated failure to do so could jeopardize the resident's health and in Resident #32's case she expected nursing staff to send her out via 911. The DON stated Resident #32 could have had a heart attack and died. The DON stated nursing staff should also report any changes to her and or the ADON, so everyone was aware of the changes and there was a continuity of care for Resident #32. Review of facility policy, Notification of Changes, undated, read in relevant part: Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Compliance Guidelines: (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. Life-threatening conditions, or b. Clinical complications. Record review of Resident #4's admission Record, dated [DATE], reflected that Resident #4 was initially admitted on [DATE] with diagnoses of schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), and Parkinson's disease (disorder of the central nervous system that affects movement, often including tremors). Record review of Resident #4's Diagnosis Report, dated [DATE], reflected that Resident #4 was diagnosed with schizoaffective disorder, depressive type on [DATE], and bipolar disorder on [DATE]. Record review of Resident #4's Quarterly MDS Assessment, dated [DATE], reflected that Resident #4 had a BIMS score of 14, indicating intact cognition. Further review reflected that Resident #4 had diagnoses of anxiety disorder, depression, bipolar disorder, and schizophrenia. Record review of Resident #4's Comprehensive Person-Centered Care Plan, dated [DATE], reflected, "Resident #4 uses psychotropic medications r/t schizoaffective disorder depressed type"; initiated on [DATE], and "Resident #4 has a mood problem r/t mood disorder due to known physiological condition with depressive features, bipolar disorder, anxiety disorder"; initiated on [DATE]. Record review of Resident #4's Skin Assessment, dated [DATE], reflected that the Wound Care Nurse had assessed Resident #4 with a cut on the right side of her cheek with no new orders. Interview on [DATE] at 10:25 AM, Resident #4 stated that somehow, she got a cut on her cheek, about an inch, next to her nose, during a surgery the week prior. Resident #4 stated that a nurse looked at it but has not told her the plan of care. Resident #4 stated that she preferred to have some sort of ointment for the cut since it is on such a prominent area of her face. Resident #4 stated she told the nurse she was concerned about the cut scarring. Interview on [DATE] at 9:35 AM, the Wound Care Nurse stated that she did a skin assessment for Resident #4 after coming back from surgery on [DATE]. The Wound Care Nurse stated she had while she had told Resident #4's physician of the laceration on her face, it was not documented anywhere and that there were no new orders. The Wound Care Nurse stated she had not talked to Resident #4 about not receiving new orders for the laceration on her face, but that the Wound Care Nurse remembered Resident #4 being concerned that the laceration would scar. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 4:37 PM, the DON stated her expectation is to complete a risk management injury of unknown origin form, which would prompt staff to follow-up with notifying the physician or NP, RP, and to detail the treatments and/or monitoring. The DON stated she was told by the Wound Care Nurse that she was not informed of Resident #4's laceration to her face because "it's a scab". The DON stated that scarring could be a negative outcome of not informing residents of treatment options when lacerations occur. The DON stated that her expectation for injuries, particularly if a resident is concerned for scarring, is to listen to their concerns and implement any suggestions for care if appropriate, such as an ointment for the facial laceration. Interview on [DATE] at 7:20 PM, NP C stated that she had seen Resident #4 on [DATE] and had ordered wound care on the laceration on Resident #4's face. NP C stated she was not aware why the Wound Care Nurse had not implemented these orders. No records were found in Resident #4's Electronic Health Record to support any wound care orders prior to [DATE] after surveyor intervention.		

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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. (continued on next page)		

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F 0755 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 observations, interviews, and record reviews 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 residents (Resident # 47) reviewed for pharmacy services. LVN H did not document an SBAR to Resident #47's physician in which Resident #47 had dislodged her intravenous access and had not received her 1 dose of the prescribed antibiotic. LVN H administered Resident #47's physician ordered antibiotic without documenting the physician's order. This failure could place residents at risk for harm due to not receiving pharmacy services as ordered. The findings included: A record review of Resident #47's admission record dated 9/10/2025 revealed an admission date of 1/4/2022 with diagnoses which included schizophrenia (a chronic mental health condition characterized by a persistent disruption in thoughts, perceptions, and behaviors), dementia (a general term for a group of conditions that cause a gradual decline in cognitive abilities, such as memory, thinking, reasoning, and language), and heart failure. A record review of Resident #47's quarterly MDS assessment dated [DATE] revealed Resident #47 was a [AGE] year-old female admitted for LTC and assessed with a BIMS score of 06 out of a possible 15 which indicated severe cognitive impairment. A record review of Resident #47's care plan dated 9/10/2025 revealed, (Resident #47) is at risk for adverse reactions related to polypharmacy . if resident has more than one prescribing medical doctor ensure that each physician has the full list of meds available including over the counter and as needed medications while ordering. A record review of Resident #47's physicians orders dated 9/8/2025 revealed the Physician prescribed for Resident #47 to receive ceftriaxone (a powerful, broad-spectrum antibiotic that works by killing bacteria) 2 grams once a day intravenously at midnight for 5 days for pneumonia starting on 9/9/2025. A record review of Resident #47's nursing progress notes dated 9/9/2025 at 1:52 AM revealed LVN I documented, Patient pulled out IV tubing. pending (intravenous access contractor) to replace iv. A record review of Resident #47's Nursing Progress notes dated 9/9/2025 at 7:57 AM revealed LVN H documented, IV Ceftriaxone 2mg/100ml started and running well. IV placed to right forearm- posterior. A record review of Resident #47's physicians orders and medication administration record for September 2025 revealed no order for a 1-time administration of ceftriaxone 2 grams intravenously at 7:57 AM on 9/10/2025. During an interview on 9/9/2025 at 7:41 PM LVN I stated Resident #47 was diagnosed with pneumonia and was prescribed Ceftriaxone intravenously daily at midnight with the first dose scheduled for 9/9/2025 at midnight. LVN I stated she was the nurse on duty at that time but had not given the medication because Resident #47 had pulled out her IV access earlier in the day and could not administer the medication. LVN I stated she worked 9/8/2025 from 2:00 PM to 9/9/2025 at 6:00 AM. LVN I stated she organized the intravenous contractor to arrive early 9/9/2025 to re-establish the intravenous access for Resident #47. LVN I stated she gave report to LVN H at 6:00 AM 9/9/2025. During an interview on 9/10/2025 at 1:39 PM LVN H stated she had received report from LVN I on 9/9/2025 at 6:00 AM which included Resident #47 had removed her IV access and had not received her first dose of her antibiotic. LVN H stated the intravenous access contractor had arrived shortly after 6:00 AM on 9/9/2025 and re-established her intravenous access. LVN H stated she had SBAR'ed (a report of situation, background, and recommendation) the physician and received a 1-time order to administer Resident #47 antibiotic now and continue with the scheduled antibiotic daily at midnight. LVN H stated she had not documented the report to the physician and had not entered the order into the physician's order summary nor the medication administration record. LVN H stated she administered the antibiotic on 9/9/2025 at 7:57AM and had not documented the administration on Resident #47's medication administration record. During an interview on 9/11/2025 at 4:30 PM the DON stated the expectation for nurses who reported a change of condition to a physician was for the nurse to accurately and timely document the report to include any new orders. The DON stated the documentation could be but not limited to the physicians' orders, the medication administration record, and the progress notes. The DON stated she received a report that LVN H had not documented the physicians new order for a 1-time medication administration of Resident #47's antibiotic nor had LVN H documented the change of condition SBAR for Resident #47's loss of intravenous access and missed first dose of her antibiotic. The DON stated LVN H also had not documented Resident #47's antibiotic administration on 9/9/2025 at 7:57 AM in Resident #47's medication administration record. The DON stated the potential negative outcome could be lack of documentation for Resident #47's medication administration		

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure a medication error rate below 5%, for 28 medication administration opportunities with 2 errors resulting in a 7.14% medication error rate, for 1 of 8 residents (Resident #57) reviewed for medication administration errors. Medication Aide J administered to Resident #57 his prescribed: Metoclopramide (a prescription medication used to treat and prevent nausea and vomiting, and to manage certain gastrointestinal issues.) Gabapentin (a prescription medication used to treat nerve pain and epilepsy.) Late by 51 minutes. These failures could place residents at risk for not receiving the therapeutic effects of their medications. The findings included: A record review of Resident #57's admission record dated 9/10/2025 revealed an admission date of 6/26/2025 with diagnoses which included diabetes mellitus with diabetic neuropathy (nerve damage related to high blood sugar levels) and gastro-esophageal reflux (a condition where stomach contents flow back up into the esophagus, causing irritation and inflammation.) A record review of Resident #57's quarterly MDS assessment dated [DATE] revealed Resident #57 was a [AGE] year-old male admitted for LTC and assessed with a BIMS score of 12 out of a possible 15 which indicated intact cognition. A record review of Resident #57's care plan dated 9/10/2025 revealed, (Resident #57) has diabetes mellitus . diabetes medication as ordered by doctor . (Resident #57) had GERD related to hyperacidity . give medications as ordered . A record review of Resident #57's physicians orders dated 9/10/2025 revealed the physician prescribed for Resident #57 to receive:- Metoclopramide oral tablet 5mg give 1 tablet by mouth three times a day at 9:00 AM, 3:00 PM, and at 9:00 PM, related to GERD.- Gabapentin oral capsule 100mg give 2 capsules by mouth two times a day at 7:00 AM and at 3:00 PM related to diabetic neuropathy. During an observation and interview on 9/9/2025 at 4:51 PM revealed Medication Aide J prepared and administered to Resident #57 his metoclopramide 5mg and his gabapentin 100mg 2 capsules 51 minutes past the prescribed 3:00 PM to 4:00 PM time frame. Medication Aide J stated she had administered Resident #57's medications 51 minutes past the prescribed 3:00 PM to 4:00 PM time frame because when she attempted to administer the medications around 3:00 PM Resident #57 was receiving a bath and she made the decision to re-attempt later in the afternoon. Medication Aide J stated she had not alerted the charge Nurse to the potential late medication administration. During an interview on 9/11/2025 at 4:30 PM the DON stated the expectation was for medication aides and nurses to administer residents' medications at the time the prescriber intended with a time frame of 1 hour prior and 1 hour past the prescribed time. The DON stated a medication ordered for administration at 3:00 PM and administered at 4:51 PM would be 51 minutes past the acceptable time frame. The DON stated the potential negative outcome could be residents would not receive the intended therapeutic effects of their prescribed medications. A record review of the facility's undated policy titled Medication Errors revealed, this is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. definitions; medication error means the observed or identified preparation or administration of medications 4 biologicals which is not in accordance with prescribers' order . medication error rate is determined by calculating the percentage of errors observed during a medication observation. The numerator is the total number of errors that is observed, both significant and non-significant. The denominator consists of the total number of observations or opportunities of error it includes all the doses observed being administered plus the doses ordered but not administered. The equation for calculating the visionary is as follows: medication error rate = number of errors observed divided by the opportunities for errors. the facility shall insure medications will be administered as follows: according to physicians' orders. 5% or as well as their events.		

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NAME OF PROVIDER OR SUPPLIER The Lev at San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE 7703 Briaridge Drive San Antonio, TX 78230	
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 2 of 7 medication carts reviewed for storage of drugs and biologicals. - The facility failed to ensure the treatment cart was locked and secured.- The facility failed to ensure the medication cart for the 400 hall was locked and secured. These failures could place residents at risk of medication misuse or drug diversion. The findings included: During an observation on 9/7/2025 at 9:03 AM revealed the facility's nurse treatment cart unlocked, unattended and unsupervised. The treatment cart had miconazole antifungal powder, an enzyme paste collagenase (an enzyme ointment which breaks down dead tissue), hypochlorous acid (HOCl), a solution designed for wound care, cleanser for debriding and irrigating wounds, ulcers, burns, and non-intact skin, and other wound care medications. During an interview on 9/07/2025 at 9:06 AM LVN K stated the treatment cart was unlocked, and LVN H had the keys. LVN K stated the cart had wound care medications, and the cart should be locked. LVN K stated the unlocked cart could have a negative outcome for residents by medications being taken out of the cart. During an interview on 9/07/2025 at 9:08 AM LVN H stated she was the nurse assigned the treatment cart. LVN H stated the cart was left unlocked. LVN H stated the keys were by the nurse's station. LVN H stated the cart contained medications and the possible negative outcome could be loss of medication control. A record review of the facility's undated policy titled "Medication Storage" revealed, "it is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and or medication rooms according to the manufacturers recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy explanation and compliance guidelines; general guidelines; all drugs and biologicals will be stored in locked compartments (i.e., medication carts, drawers, refrigerators, medication rooms) under proper temperature controls. &hellip;." Observation and interview on 09/09/2025 at 4:43 PM, LVN G was observed in a room with a resident administering medications. His medication cart was observed sitting outside of the resident's room unlocked and unattended. LVN G stated his medication cart should have been locked if he walked away from it. Interview on 09/11/2025 at 4:37 PM, the DON stated her expectation is for staff to lock their medication carts prior to walking away from the cart with no screen showing any patient information and no medications sitting on top of the cart. The DON stated there is a risk to residents if a medication cart is left unlocked as other residents could potentially get into the medication cart or anything on top of the cart.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview and record review the facility failed to store, distribute and serve food in accordance with professional standards for food service safety in 1 of 1 Kitchen reviewed for sanitary conditions. Dietary staff failed to ensure: a. the plastic bag of powdered milk was sealed stored in the stand-up refrigerator, b. the cookies they provided for snacks were not expired and c. the temperature logs were posted on the walk-in refrigerator, freezer and stand-up refrigerator and failed to record daily temperatures for all stated appliances. These deficient practices could place all residents at risk for food borne illnesses. The findings were: Observation on 09/07/2025 at 9:15 AM, during Initial tour, revealed an open plastic bag of powdered milk. Further observation revealed the temperature log on the stand-up refrigerator, freezer and walk-in refrigerator ended on 8/31/25. There were no other logs posted anywhere in the kitchen and there were no current temperatures of any of the appliances. Interview on 9/7/25 at 9:10 AM with [NAME] L revealed the plastic bag of powdered milk should be sealed because mold could grow in it or other food items could fall inside the bag and contaminate the milk. [NAME] L stated it could cause the residents to get sick. She stated they served powdered milk to all residents for breakfast. [NAME] L further stated the DS usually posted the temperature logs on the stand-up refrigerator, freezer and walk-in refrigerator. She stated she did not know where the DS kept the logs. [NAME] L stated she would read the temperature gauge on the appliances to make sure they were within range but did not record them anywhere because the logs had not been updated. She stated the refrigerators should not be over 41 degrees and the freezer should be between 0 and 32 degrees. Interview on 9/7/25 at 3:35 PM with the DS revealed she left the temperature logs for the walk-in refrigerator, stand-up refrigerator, and the freezer with the Cooks. They should have posted the logs on the appliances but should have made sure they were in place while making rounds in the kitchen. Interview on 9/8/25 at 11:24 AM with [NAME] M revealed the temperature log on the stand-up refrigerator, freezer and walk-in refrigerator ended on 8/31/25 as well as the food temperature logs. He stated he did not know where the DS kept the logs but had continued to take temperatures. He stated he would take daily food temperatures on write them on the back of the production sheets but eventually they had been thrown away. Interview on 9/8/25 at 1:53 PM with the DS revealed she was responsible for ensuring all the temperature logs for the walk-in refrigerator, stand-up refrigerator, the freezer and for the food were provided and in place. She stated she had taken a lot of time off in the last couple of weeks due to personal reasons and guessed she missed making sure the temperature logs were available and that dietary staff was recording the temperatures on the appliances on for the food. The DS stated it was important temperatures were taken of the appliances and the food to ensure the temperatures were within a safe range for service otherwise it could make the residents sick. The DS also stated that all plastic bags of food in the refrigerator should be sealed to prevent it from being contaminated and if left open and served it could also make the residents sick. Observation and interview on 9/10/25 at 12:41 PM revealed a bin of bagged cookies with the date 8/27/25 placed on the prep table placed outside the pantry. There was not an end date. DA O stated they baked the cookies yesterday, but the date on the bin was not updated. DA O stated it should have been updated to reflect the actual date the cookies were baked. She stated the cookies were good for three days and should not be served beyond the three days because it could make the residents sick. Interview on 9/10/25 at 12:55 PM with the DS revealed dietary staff prepped snacks every morning for the afternoon and evening snack times for the same date and for the following morning snack time at 10 AM. She stated any leftover snacks left over after the following morning were discarded. The DS stated dietary staff probably forgot to change the date on the snack bin. She stated the cookies were not cooked and delivered in bulk form. She presented a box of oatmeal cookies and stated they received the cookies on 8/24/25 which was written on the box. She stated the best by date, was 9/3/25 which was the expiration date. She stated dietary staff should not serve them because it could make the residents sick but stated there was another box of cookies and those were the cookies dietary staff prepped for the residents. She stated the box was thrown away. When asked when it was thrown away, she stated 1 or 2 days ago. Review of a facility policy, Date Marking for Food Safety, undated revealed in relevant part 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. 5. The discard day or date may not exceed the manufacturer's use-by date. 8. Note: prepared foods that are delivered to the nursing units shall be discarded within two-hour, if not consumed. These items shall not be refrigerated as the time/temperature controls cannot be verified. Review of a facility policy, Food Safety		

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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 observations, interviews, and record reviews the facility failed to establish an infection prevention and control program with written standards, policies, and procedures for standard and transmission-based precautions to be followed to prevent spread of infections for 1 of 3 residents (Resident #7 and Resident #28) reviewed for disinfecting the glucometer in between Residents. LVN G did not disinfect the glucometer after assessing Resident #28's blood sugar level and then attempting to assess Resident #7's blood sugar level. This failure could place residents at risk for blood borne pathogens and infections. The findings included: Resident #28A record review of Resident #28's admission record dated 9/10/2025 revealed an admission date of 8/8/2025 with diagnoses which included type II diabetes, infectious gastroenteritis (common stomach flu), and sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection.) A record review of Resident #28's Quarterly MDS assessment dated [DATE] revealed Resident #28 was a [AGE] year-old male admitted for LTC. A record review of Resident #28's physicians orders dated 9/10/2025 revealed the physician prescribed for Resident #28 to receive insulin injections before meals per a sliding scale as per his blood sugar levels. Resident #7A record review of Resident #7's admission record dated 9/10/2025 revealed an admission date of 2/18/2025 with diagnoses which included diabetes, pneumonia, and sepsis (a life-threatening illness that develops when an existing infection triggers an extreme immune system response in your body.) A record review of Resident #7's quarterly MDS assessment dated [DATE] revealed Resident #7 was a [AGE] year-old female admitted for LTC. A record review of Resident #7's physicians orders dated 9/10/2025 revealed the physician prescribed for Resident #7 to receive insulin injections before meals per a sliding scale as per his blood sugar levels. During an observation on 9/8/2025 at 4:20 PM revealed LVN G prepared a glucometer (a portable medical device used to measure blood glucose sugar levels) without disinfecting the glucometer and proceeded to Resident #28 and assessed Resident #28's blood sugar level by developing a drop of blood from Resident #28's finger. Further observation revealed LVN G continued to the medication cart to document Resident #28's blood sugar levels. LVN G was observed to preform hand hygiene but had not disinfect the glucometer. Continued observation revealed at 4:29 PM LVN G proceeded to Resident #7 with the same glucometer used to assess Resident #28. LVN G attempted to assess Resident #7 by developing a drop of blood from Resident #7 when the state surveyor intervened and impeded LVN G prior to developing a drop of blood from Resident #7. During an interview on 9/8/2025 at 4:30 PM LVN G recognized he had not disinfect the glucometer in between assessing Resident #28 and Resident #7. LVN G stated he would disinfect the glucometer with an approved chemical wipe for blood borne pathogens. LVN G stated the potential risk for residents could be cross contamination which could include blood borne pathogens. During an interview on 9/11/2025 at 4:30 PM the DON stated the expectation for assessing residents for blood sugar levels was for the nursing staff to disinfect the glucometers prior to and in between residents' use. The disinfectant must be a chemical wipe designated to disinfect for blood borne pathogens. The DON stated the potential negative outcomes for not disinfecting the glucometer in between resident use was cross contamination for infections. A record review of the facility's undated policy titled Glucometer Disinfection revealed, the purpose of this procedure is to provide guidelines for the disinfection of capillary blood glucose sampling devices to prevent transmission of bloodborne diseases to residents and employees. Definitions: disinfection is a process that eliminates many or all pathogenic microorganisms except bacterial spores on inanimate objects. policy explanation and compliance guidelines, the facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi resident use.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview and record review the facility failed to ensure to maintain all mechanical and electrical equipment in safe operating condition in 1 of 1 kitchen reviewed for equipment. The facility failed to ensure the temperature gauge on the dishwasher was working properly and the sanitation level was reaching between 50 PPM and 100 PPM to properly disinfect the dishware. 2. The DS failed to provide an updated water temperature and sanitation log for the dishwasher for documenting readings to ensure the equipment was working properly. These deficient practices could place residents at risk of not having equipment working in safe conditions. The findings were: A record review of the chemical temperature log for the month of September 2025 revealed there was not a log for the month of September 2025. A record review of the chemical temperature log for the month of August 2025 revealed 93 opportunities to document the water temperature and sanitation level with 21 of the 93 opportunities documented were below 50 PPM for the sanitation level and there were 8 missing opportunities for documentation. They were blank. Observation and interview on 09/07/2025 at 9:19 AM revealed DA A running the dishwasher and taking a reading of the level of sanitation in the dishwasher. Interview with DA A revealed the temperature gauge was not reading higher than 103 degrees. She stated the gauge was not working but mentioned it was working last Thursday (9/4/25), on the last day she worked before her days off. Further observation revealed she tested the sanitation level by dipping test strip and inserted into the reservoir on the outside of the dishwasher. She stated it was barely reaching 25 PPM and noted the color on the test strip did not match the color designating 50PPM. DA A stated she noted the sanitation level was reading low for at least the past three weeks and had brought it up to the DS's attention. She stated last Thursday, 9/4/25, she checked the sanitization level twice and the results were also low that day. She stated it should read at least 50 PPM. for it to kill all the bacteria otherwise it could make the residents sick. DA A further stated she was not documenting the water temperature or the sanitation level because there was not an updated log for September 2025. During an observation and interview on 9/7/2025 at 10:18 AM revealed DA A in the kitchen plating desserts in dishware she had previously washed in the morning. DA A presented the chemical / temperature logs for August 2025 which were kept on a clipboard by the DS's office. DA A stated she tested the water chemical sanitizer level prior to using the dishwasher. DA A stated the chemical level was obtained by using a chemical test strip dipped in the dishwasher water while in operation and comparing the test strip to the color scale on the side of the test strip container / bottle. DA A stated for days in August and September the test strip was below the required 50 PPM level and she had reported the finding to the DS. DA A stated she had measured the dishwasher chemical sanitizer water level this morning and the finding was below 50 PPM somewhere around 25 PPM. DA A stated she did not document the findings because there was no log for September 2025. DA A stated she recalled on 9/4/2025 the dishwasher chemical sanitization water level was below 50 PPM. Interview on 09/07/2025 at 10:21 AM with the DS revealed dietary aides were assigned dishwashing duties to include checking the dishwasher for proper sanitization chemical levels and water temperature three times a day before using the dishwasher to wash and sanitize dishes, utensils, pots pans etc. The DS stated the chemical sanitizer would be checked by using a chemical litmus paper strip and placing the test strip in the chemically infused water while the dishwasher was washing dishes and the test strip would be held against the color palette on the side of the litmus paper strip bottle. The DS stated the color reading should match the color palette to indicate 50 PPM of chemical sanitizer in the water and the minimum water temperature should reach 120 F. The DS stated both the chemical level of 50 PPM and the 120 F temperature were required for the dishwasher to effectively sanitize the dishes. The DS stated she would have the dietary aides do a demonstration to ensure they were doing it correctly. The DS stated 10 minutes ago she was informed by Dietary Aide A that Dietary Aide A had exchanged the chemical sanitizer because the chemical sanitizer was not reaching 50 PPM water saturation. The DS stated the lack of documentation and chemical sanitizer levels below 50 PPM could have a negative potential for germs and un-sanitized dishes and utensils. Interview on 9/7/25 at 3:35 PM with the DS revealed she did not know the sanitation levels for the dishwasher were reading 45 PPM before today, 9/7/25. She stated no one had said anything to her. She stated they received the new dishwasher a couple of months ago. She stated if not in the facility, dietary staff was to call her when there was a problem with any of the equipment. She stated she had in-serviced staff related to operating procedures for the dishwasher, temperature levels which should be between 120 and 140 degrees and in reading the sanitation levels in the water which should read		