STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675002	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Antonio West Nursing and Rehabilitation	636 Cupples Rd San Antonio, TX 78237

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. (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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents had the right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility was changed for one of one resident (Resident #1) reviewed for room change. The facility did not provide Resident #1's guardian with a written notice prior to a room change or the right to refuse on 06/16/2025. This deficient practice could place residents at risk of being displaced without notice and/or reason to accommodate other individuals.The findings included: Record review of Resident #1's admission Record, dated 10/07/2025, revealed an [AGE] year-old male admitted on [DATE]. Resident #1 had a listed guardian as his only contact. Resident #1's room assignment noted as 012-B. Record review of Resident #1's Diagnosis Report, dated 10/07/2025, revealed diagnoses including vascular dementia (a change in thinking and memory that occurs when the brain experiences a disruption in blood flow), chronic obstructive pulmonary disease (a type of progressive lung disease), and interstitial pulmonary disease (inflammation and progressive scarring of lung tissue). Record review of the Daily Census, dated 10/05/2025 and printed 10/06/2025, reflected Resident #1 was assigned room [ROOM NUMBER]-B. Record review of Resident #1's quarterly MDS, dated [DATE], reflected Resident #1 was rarely/never understood, had short and long-term memory problems, and was severely impaired for daily decision making. Record review of Resident #1's care plan, dated 07/31/2025, revealed Resident #1 was at risk for injury due to wandering behavior. Resident #1 was noted to reside in the secure unit. The care plan focus was initiated and revised on 03/05/2025. Record review of Resident #1's progress notes, dated 10/05/2025 (day prior to room change) to 10/06/2025 (day of room change), indicated no documentation or notification to Resident #1's guardian about why a room change was made. Record review of Resident #1's EMR on 10/07/2025 did not reveal documentation of a notification to and/or consent by Resident #1's guardian for a room change. During an observation and attempted interview on 10/06/2025 at 03:42 p.m., Resident #1 was observed in the dining area of the facility secure unit interacting with a facility staff member. Resident #1 appeared calm but confused. Attempted interview with Resident #1 revealed Resident #1 was not interviewable. Resident #1's name was observed to be labeled outside the entry to room [ROOM NUMBER]. During an interview on 10/08/2025 at 02:49 p.m., LPN A stated Resident #1 was moved rooms on either Saturday or Sunday morning, could not recall day, due to an incident in which Resident #1 had pulled on the curtain resulting in the curtain railing having disconnected from the ceiling. He stated that he notified the facility maintenance and administration on call, human resources (HR) of the incident and Resident #1's room change. He stated he did not notify the family/guardian because he thought the rom change would only be temporary, until the room ceiling was repaired. He stated that if he had thought the room change was going to be an official room change, he would have notified the family/guardian of the switch. During an interview on 10/08/2025 at 03:41 p.m., the HR stated she received notification from a staff member that a resident had pulled the curtain rod down in their room. She stated he had verified that the resident had been relocated to another room and that maintenance was notified. She stated she had believed the room change was temporary and not considered a permanent move. During an interview on 10/08/2025 at 05:16 p.m., the DON stated Resident #1 pulled on his privacy curtain resulting in it coming down. She stated the rail for the privacy curtain was now bent and Resident #1's prior room, room [ROOM NUMBER], was currently unoccupied. She stated she believed someone reached out to Resident #1's guardian regarding his room change but would have to check the notes. During an interview on 10/08/2025 at 05:51 p.m., the ADMIN stated as far as she knew Resident #1 was moved rooms temporarily. She stated she did not know if the guardian was contacted but that the facility procedure was for the staff to contact the family/guardian and usually document the notification in a progress note. She stated the importance of notifying the family/guardian was to obtain consent for the move, indicating they were okay with it. During an interview on 10/08/2025 at 06:22 p.m., the DON stated she could not locate in Resident #1's notes of his guardian having been contacted regarding the room change. She stated that she reached out to LPN A, who stated he did not notify the guardian since he thought the room change was temporary. The DON stated that even if LPN A reached out to Resident #1's guardian it would have been after-hours and the guardian's contact number does not allow messages to be left. She stated she told LPN A that even if a resident's move was temporary, the resident representative would still need to be notified. During an interview on 10/13/2025 (after investigation exit) at 10:50 a.m., Resident #1's guardian stated he did not

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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F 0580 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 observation, interview and record review, the facility failed to consult with the resident's physician and notify the representative when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for one of eleven residents (Resident #2) reviewed for quality of care. The facility failed to notify Resident #2's resident representatives of Resident #2's increase of exit seeking behavior with refusal for redirection resulting in police intervention observed on 10/03/2025. This failure could place residents at risk of unmet physical and psychosocial needs, physical harm and a decrease in quality of life and could result in the family or representative not being aware of conditions that may require them to make medical decisions. The findings included: Record review of Resident #2's admission Record, dated 10/07/2025, revealed a [AGE] year-old male initially admitted on [DATE] and readmitted on [DATE]. Resident #2 had two emergency contacts, emergency contact #1 and emergency contact #2. Record review of Resident #2's Diagnosis Report, dated 10/07/2025, revealed diagnoses including schizoaffective disorder (a chronic mental illness involving symptoms of schizophrenia and characterized by symptoms such as delusions and hallucinations), type 2 diabetes mellitus (a condition that develops with the way the body regulates and uses sugar as fuel), and dementia (a general term for impaired ability to remember, think, or make decisions). Record review of Resident #2's quarterly MDS, dated [DATE], reflected Resident #2 had a BIMS of 07, indicating he had severe cognitive impairment. He was noted to have had physical and verbal behaviors, rejected evaluation or care, and wandered 1-3 days per week. He used a walker and required supervision or touching assistance for walking 50 feet with two turns or at least 150 feet. Record review of Resident #2's care plan, dated 09/18/2025, revealed Resident #2 had the following focuses and interventions:- Behavioral Complex Care Plan: behaviors which affect others: Physical behavioral symptoms, date initiated 08/06/2024 and revised 09/12/2025, with interventions: - If resident can not be redirected or calmed, and if safe to do so, staff to attempt to perform cares at a later time after resident is more calm., date initiated 08/06/2024, - Redirect with snacks and verbal redirection., date initiated 01/27/2025, - Staff to involve family as necessary to assist with behavioral management, date initiated 08/06/2024, and - Walk with Resident outside as tolerated., date initiated 01/27/2025. - At risk for elopement for elopement as evidenced by History of attempts to leave facility unattended, Impaired safety awareness, date initiated 08/22/2025 and revised 06/04/2025, with interventions: - Provide Resident with safe place to wander if necessary., date initiated 08/22/20224 and - Use wander guard, date initiated 12/06/2024. - At risk for injury d/t wanders, date initiated 08/22/2024 and revised 04/15/2025, with interventions: - Assess for emotional or psychological distress, such as anxiety, fear, or felling lost., date initiated 08/22/2024, - Assess for physical distress or needs, such as hunger, thirst, pain, discomfort, or elimination., date initiated 08/22/2025, - Frequent monitoring for exit seeking behaviors and/or actions, every shift, date initiated 09/30/2024, - Refer to psych [psychosocial] services., date initiated 10/01/2024, - Use wander guard, date initiated 08/22/2024 and revised 12/06/2024, and - When wandering, redirect resident to another activity, date initiated 08/22/2024. Record review of Resident #2's progress notes, dated 10/06/2025 revealed:- Incident note dated 10/03/2025 at 10:53 p.m. by RN B, Resident left the facility through the door at D hall. Almost all the staff went out trying to get him back in without any success. Resident was hitting staff and was almost running of [sic] into the road. Police was [sic] called. He continued walking on the sidewalkguided [sic] by staff very close to the end of the road that terminates into the highway before the cops arrived. On arrival, they gently ask [sic] [Resident #2] what was going on and the [sic] lashed out at then [sic], tried fighting them so they had to restrained [sic] and cuff him. He was forces [sic] into the vehicle snd [sic] drove him to the front of the facility and let him back in. - Administrator note dated 10/04/2025 at 05:14 p.m. by the ADMIN, noted to be LATE ENTRY, Admin followed up with staff to ensure that the resident was supervised by staff throughout his duration outside the facility. Staff confirmed this. Elopement risk and wandering assessments updated. Resident currently being followed by psych services, provider notified for follow up. Will continue to monitor. - Nurses note dated 10/06/2025 at 10:33 a.m. by LPN C, Call placed to [Resident #2's emergency contact #2] in regard to resident if could get labs and maybe a UA& [sic] C&S d/t reported behaviors. Record review of Resident #2's Elopement Assessment, dated 09/05/2025, revealed Resident #2 was At Risk for elopement. He was documented as not having past wandering behaviors as part of his past, not displayed wandering

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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. (continued on next page)

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F 0657 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 interviews and record reviews, the facility failed to ensure that the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for two of eleven residents (Resident #1 and Resident #3) reviewed for care plans. 1. The facility failed to update or add interventions to Resident #1's care plan regarding behaviors that impact his safety, stripping the bed and the suspected behavior of repeatedly pulling on the privacy curtain resulting in pulling the curtain track down from the ceiling. 2. The facility failed to update or add interventions to Resident #3's care plan regarding reported suicidal ideation that occurred on 10/05/2025. These failures could place residents at risk of not receiving the necessary services or having the appropriate interventions to meet their current needs. The findings included: 1. Record review of Resident #1's admission Record, dated 10/07/2025, revealed an [AGE] year-old male admitted on [DATE]. Record review of Resident #1's Diagnosis Report, dated 10/07/2025, revealed diagnoses including vascular dementia (a change in thinking and memory that occurs when the brain experiences a disruption in blood flow), chronic obstructive pulmonary disease (a type of progressive lung disease), and interstitial pulmonary disease (inflammation and progressive scarring of lung tissue). Record review of Resident #1's quarterly MDS, dated [DATE], reflected Resident #1 was rarely/never understood, had short and long-term memory problems, and was severely impaired for daily decision making. Record review of picture allegedly taken 10/05/2025 by LPN A revealed Resident #1 in a resident room, lying in a bed with the room's privacy curtain and track system disconnected from the drop ceiling and part of the drop ceiling broken and on the floor. Resident #1 and the bed appear to be outside the area of debris. Resident#1's bed noted to not have sheets attached to the bed with a naked mattress under Resident #1, but Resident #1 appeared to be wrapped in a sheet. Record review of Resident #1's care plan, dated 07/31/2025, revealed Resident #1 had cognitive impairment due to diagnosed dementia, had a mood problem related to the disease process of dementia with behaviors, was at risk for behaviors related to demonstrates physically abusive behaviors, and was at risk for injury due to wandering behavior. The care plan did not note Resident #1's behaviors of stripping the bed or pulling on his privacy curtain resulting in it being pulled from the ceiling. During an observation and attempted interview on 10/06/2025 at 03:42 p.m., Resident #1 was observed in the dining area of the facility secure unit interacting with a facility staff member. Resident #1 appeared calm but confused. Attempted interview with Resident #1 revealed he was not interviewable. During an interview on 10/08/2025 at 02:00 p.m., LPN D stated she worked with Resident #1 on Monday morning, 10/06/2025. She stated Resident #1 had been moved rooms when she came in for her shift because Resident #1 probably pulled down the curtains. She stated Resident #1 had done that before. She stated Resident #1 also had a history of pulling the sheets off his bed. During an interview on 10/08/2025 at 02:49 p.m., LPN A stated there was an incident on either Saturday or Sunday morning, could not recall date, in which Resident #1 had pulled on the curtain resulting in the curtain railing having disconnected from the ceiling. He stated Resident #1 did not sustain injuries and the falling debris did not fall on him. He stated Resident #1 had a behavior of pulling his sheets off his bed as soon as staff put them on; however, the staff continue to try to keep them on. LPN A stated he was unsure if Resident #1's behavior of stripping the bed was care-planned, but he knew Resident #1 had that behavior. He stated the curtain having been pulled from the ceiling was the second time Resident #1 had demonstrated that behavior. During an interview on 10/08/2025 at 05:16 p.m., the DON stated Resident #1 takes all of his sheets off his bed and wraps himself in them. She stated she would consider that action a behavior but did not know if the behavior was noted in his care plan. She stated she thought the facility should care plan for it. She stated Resident #1's action of pulling the curtains down in his room was assumed since she was unsure if staff ever witnessed him doing it; however, she stated that was the only possibility that made sense. She stated she would consider that action a behavior if staff witnessed it and that documented behaviors should be care-planned so appropriate interventions could be created. She stated that for dementia residents the staff might have to remove the privacy curtains for safety reasons, but there must be a documented reason. She stated Resident #1's behavior of stripping the bed having not been care planned would not impact him because staff would just keep making the bed. She stated Resident #1 had not sustained any injuries from the curtain track having been pulled down in his room. During an interview on 10/08/2025 at 05:51 p.m., the ADMIN stated the known behavior of a resident for stripping the bed would typically be care-planned. She stated incidents such the curtain track having been pulled from the