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	01/09/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs that are identified in the comprehensive assessment, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 4 of 9 residents (Resident #1, Resident #2, Resident #3, and Resident #4) reviewed for care plans. 1. The facility failed to ensure Resident #1's care plan included his having exhibited physical aggression toward another resident. 2. The facility failed to ensure Resident #2's care plan included his having experienced physical aggression from another resident. 3. The facility did not have Resident #3's care plan after the resident had a resident-to-resident physical altercation on 08/17/2025. 4. The facility did not have Resident #4's care plan after the resident had a resident-to-resident physical altercation on 10/01/2025. This failure could practice place residents at risk of not receiving proper care and services.Findings included: 1. Record review of Resident #1's face sheet, dated 01/06/2025, revealed he was admitted on [DATE] with diagnoses which included: schizophrenia (a severe brain disorder disrupting thought, perception, and behavior, causing hallucinations (like hearing voices), delusions (false beliefs), disorganized thinking, and flat emotions), anxiety disorder (mental health conditions characterized by excessive fear, worry, and dread that are disproportionate to the situation, interfering with daily life and functioning), and mild cognitive impairment of uncertain or unknow etiology (memory/thinking problems are worse than normal aging but not severe enough to interfere with daily life). Record review of Resident #1's Quarterly MDS assessment, dated 11/27/2025, revealed the resident's BIMS score 15 for intact cognition. Record review of Resident #1's progress notes dated 11/30/2025 revealed Nurse heard yelling from resident room, upon entering room resident he is standing over roommate holding his fist up as if he punched resident.Resident is very agitated and stated, he started talking to me in a way I don't like.so I punched him. Record review of Resident #1's care plan, with a target date of 01/07/2026, revealed there was not a care plan reflecting Resident #1's physical aggression toward another resident. Observation on 01/07/2026 at 8:20 AM revealed Resident #1 in the dining room socializing with other residents, no aggressive behavior observed. Observation and interview on 01/08/2026 at 12:45 p.m. Resident #1 was observed sitting in the lobby (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	area with female resident no aggressive behavior observed. Resident #1 denied the incident on 11/30/2025. 2. Record review of Resident #2's face sheet, dated 01/06/2026, revealed he was admitted on [DATE] with diagnoses which included: schizoaffective disorder (a serious mental illness blending symptoms of schizophrenia (like hallucinations or delusions) with a mood disorder (depression or bipolar mania)), anxiety disorder (mental health conditions characterized by excessive fear, worry, and dread that are disproportionate to the situation, interfering with daily life and functioning), and paraplegia (paralysis affecting the lower half of the body, typically from the waist down, resulting from damage to the thoracic, lumbar, or sacral spinal cord, causing loss of movement, sensation, and control of bowels/bladder). Record review of Resident #2's Significant Change MDS assessment, dated 10/31/2025, revealed the resident's BIMS score 15 for intact cognition. Section E of the Significant Change MDS assessment revealed Resident #2 with verbal behavioral symptoms and other behavioral symptoms not directed toward others. Record review of Resident #2's progress note dated 11/30/2025, revealed This nurse heard yelling from the hallway, entered room and resident was laying in the bed, roommate standing over him with his fist balled up above resident's head.Stated his roommate hit him in the head. Resident immediately removed and assessment completed. Record review of Resident #2's care plan, with a target date 02/02/2026, revealed there was not a care plan reflecting Resident #2's having experienced physical aggression from another resident. Observation on 01/07/2026 at 8:25 AM revealed Resident #2 sleeping in his bed with call light within reach. Observation and interview on 01/08/2026 at 1:00 p.m. revealed Resident #2 lying in bed with call light within reach. Resident #2 stated he did not have any concerns regarding his safety in the facility and stated he had only one incident. Resident #2 further stated staff moved him from the room. Resident #2 denied himself having exhibited any behaviors himself. Observation and interview on 01/09/2026 at 7:47 a.m. the SW reviewed Resident #1's and Resident #2's care plans, and she stated she did not see a care plan for either resident regarding Resident #1 having shown physical aggression toward Resident #2. The SW stated both her and the MDS coordinator create the behavior care plans. The SW further stated usually, she would do the behavior care plans if there was a resident-to-resident incident, but if she was not available anyone from the IDT could do them. The SW stated this would be something they would typically care plan. The SW stated the purpose of the care plan was to provide interventions and have them put in place to help avoid further occurrences of the behavior. The SW stated when there was a resident-to-resident incident the IDT would meet and care plan the behavior. Observation and interview on 01/09/2026 at 7:59 a.m. the MDS LVN stated they would have a risk meeting the next day regarding anything that happened the day before and care plan behaviors at that time. The MDS LVN stated behaviors were care planned by the SW when they had the IDT meetings. The MDS LVN was observed reviewing Resident #1's and Resident #2's care plans on her laptop. The MDS LVN stated she could not locate the behavior in the care plan for Resident #1 and was unable to locate it in Resident #2's care plan. The MDS LVN stated that the care plan was to alert the staff to the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	different types of behaviors to look out for and for the safety of the residents. The MDS LVN stated that care plan was to notify the staff how to take care of the residents. During an interview on 01/09/2026 at 10:49 a.m. the Administrator stated the IDT met and reviewed the incidents to ensure they put interventions into place. The Administrator further stated the SW was responsible for care planning the behaviors of residents, but when she was not available the MDS LVN was responsible. The Administrator stated the importance of the care plan was for communication with the staff. The Administrator stated by not care planning behaviors it would increase the potential of an incident happening again. Record review of facility's Care Plans, Comprehensive Person-Centered policy, revision date, 10/24/2022 read, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 7. The care planning process will: Bl Include an assessment of the resident's strengths and needs; and. 8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes: b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems;. 10. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. 3. Record review of Resident #3's face sheet, dated 01/07/2026, revealed the resident was a [AGE] year old female admitted on [DATE] with diagnoses of Alzheimer's disease (progressive disease that destroy memories and other important mental functions), type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar levels, leading to persistently high blood glucose levels), and depression (lowering of a person's mood). Record review of Resident #3's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 0 out of 15 which indicated the resident had severe cognitive impairment, and the resident had verbal and physical behavioral symptoms toward others. Record review of Resident #3's incident report, dated 08/17/2025, revealed Resident #3 hit another resident in the secure unit, so staff separated them immediately, and a nurse assessed both residents, but no injury was noted. Further record review of the incident report indicated both residents did not recall what happened. Record review of Resident #3's facility IDT meeting, dated 08/18/2025, revealed the facility had new intervention of checking Resident #3 every 15 minutes and referring to psychiatric services regarding Resident #3's behavior. Record review of Resident #3's comprehensive care plan, date initiated 05/16/2025, revealed there were no care plans reflecting Resident #3's having experienced physical aggression from another resident on 08/17/2025 and new interventions included checking Resident #3 every 15 minutes and referring Resident #3 to psychiatric services. Observation on 01/06/2026 at 11:30 a.m. Resident #3 was observed sitting on the bed and was unable to interview because of the resident's low cognition function. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/07/2026 at 11:22 a.m., the Social Worker stated Resident #3 had a resident-to-resident altercation on 08/17/2025, and the facility had an IDT meeting, and initiated new interventions, such as checking Resident #3 every 15 minutes and referring Resident #3 to psychiatric services. However, the Social Worker forgot to make Resident #3's care plan after the IDT meeting, and making care plans for behavioral issues were the SW's responsibility, and not having care plans might cause the resident to receive inappropriate care. 4. Record review of Resident #4's face sheet, dated 01/07/2026, revealed the resident was a [AGE] year old male admitted [DATE] and readmitted on [DATE] with diagnoses of dementia (loss of memory and thinking ability), psychotic disorder (people lose some contact with reality), depression (lowering of a person's mood), and hallucinations (an experience involving the apparent perception of something not present). Record review of Resident #4's Significant Change MDS, dated [DATE], revealed the resident's BIMS score was 5 out of 15 which indicated the resident had severe cognitive impairment, and the resident had no verbal and physical behavioral symptoms toward others. Record review of Resident #4's incident report, dated 10/01/2025, revealed Resident #4 pulled some resident out of the bed because the resident was sleeping on Resident #4's bed. Staff separated both residents immediately and assessed, but no injury was noted. Further record review of the incident report indicated both residents did not recall what happened. Record review of Resident #4's facility IDT meeting, dated 10/02/2025, revealed new interventions were checking Resident #4 every 15 minutes and referring Resident #4 to psychiatric services. Record review of Resident #4's comprehensive care plan, date initiated 07/09/2025, revealed there were no care plans reflecting Resident #4's having experienced physical aggression from another resident on 10/02/2025 and new interventions included checking Resident #4 every 15 minutes and referring Resident #4 to psychiatric services. Observation on 01/06/2026 at 11:40 a.m. Resident #4 was observed sitting on the wheelchair in front of his room and was unable to interview because of the resident's low cognition function. During an interview on 01/07/2026 at 11:22 a.m., the SW stated Resident #4 had a resident-to-resident altercation on 10/01/2025, and the facility had an IDT meeting, and new interventions included checking Resident #4 every 15 minutes and referring Resident #4 to psychiatric services. However, the Social Worker forgot to make Resident #4's care plan after the IDT meeting, and making care plans for behavioral issues was the SoW's responsibility, and not having care plans might cause the resident to receive inappropriate care. Record review of facility's Care Plans, Comprehensive Person-Centered policy, revision date, 10/24/2022 read, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: 7. The care planning process will: Bl Include an assessment of the resident's strengths and needs; and. 8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes: b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems;. 10. Identifying problem areas and their causes and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, interviews, and record reviews, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #5) of 9 residents reviewed for medical records. The facility failed to ensure Resident #5's electronic medical diagnosis list accurately indicated the resident had dementia with anxiety on the list, but the physician note indicated, the resident had dementia with anxiety. This failure could place residents at risk for missed treatment and medications which could result in a decline in health and well-being.Findings included: Record review of Resident #5's face sheet, dated 01/08/2026, revealed the resident was a [AGE] year old male, admitted [DATE] and re-admitted [DATE] with diagnoses of hyperlipidemia (too many lipid or fats such as cholesterol), cerebral infarction (blood flow to the brain is blocked), encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition), and hypertension (high blood pressures). Record review of Resident #5's admission MDS, dated [DATE], revealed the resident's BIMS score was 7 out of 15, which indicated the resident had severe cognitive impairment and required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) to most activities of daily life such as sit to stand, chair-to-bed, and toilet transfer. Record review of Resident #5's physician progress note, dated 12/01/2025, revealed the resident had dementia with anxiety as one of the active medical problems. Record review of Resident #5's electronic medical diagnoses list on 01/06/2026 revealed the resident did not have dementia with anxiety as one of the active medical problems. Observation on 01/08/2026 at 10:01 a.m. Resident #5 was observed sitting on the wheelchair in front of the nursing station and said he was feeling safe in the facility. However, Resident #5 could not say what kinds of medical problems he had due to his low cognitive function. During an interview on 01/08/2026 at 10:48 a.m. the DON said Resident #5 had dementia with anxiety, and the resident's primary care physician also mentioned the resident had dementia with anxiety, but Resident #5's electronic medical diagnosis list did not have dementia with anxiety on the lists. The DON said tt was inaccurate and did not know why the diagnosis of dementia with anxiety was missing from the list. The DON said Resident #5's electronic medical diagnosis list should have been accurate to prevent providing incorrect care to the resident. The DON said she had the responsibility to oversee residents had accurate medical diagnoses lists. Record review of the facility policy, titled Charting and Documentation, dated 2018, revealed, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record.