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	02/13/2026

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

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide personal privacy during personal care for 1 of 6 Residents (Resident #1) who were reviewed for care. CNA A failed to ensure Resident #1 was not exposed to anyone passing his room when she opened Resident #1's door during care. This deficient practice could place residents at risk for feeling embarrassed and compromise the resident's dignity. The findings were:Review of Resident #1's admission MDS assessment, dated 1/23/26, revealed he was admitted to the facility on [DATE] with diagnoses of malnutrition, cerebral infarction (stroke) due to occlusion or stenosis (blockage/narrowing) of small artery, dysphagia (trouble swallowing) following cerebral infarction, encounter with attention to gastrostomy (enteral feeding) and cognitive communication deficit (condition where cognitive impairments, rather than language or speech problems, disrupt a person's ability to communicate effectively). Further review revealed Resident #1's BIMS score was severely cognitive impaired, he was totally dependent for all ADL care including toileting and personal hygiene, and he had a feeding tube. Review of Resident #1's Care Plan, revised on 2/6/26, read Resident #1 had Impaired Communication due to: CVA (stroke) with aphasia (trouble swallowing), cognitive communication deficit, impaired physical functioning related to cognitive impairment, debility/weakness, Hemiplegia/Hemiparesis (paralysis), neurological disease CVA (stroke), prolonged hospitalization, lack of coordination, abnormalities of gait and mobility and required 1 to 2 persons with toileting and hygiene. Further review revealed Resident #1 required enteral tube feeding related to oropharyngeal (middle section of the throat) dysphagia (trouble swallowing), failure to thrive. Observation and interview on 2/12/26 at 11:38 AM revealed CNA A came out of Resident #1's room. She opened the door exposing Resident #1 who was in bed A (closest to the door). The privacy curtain was pulled but it was not pulled around the foot of the bed. Resident #1 was lying in bed wearing only a brief. He was not wearing anything else and was connected to a G-tube. CNA A stated she opened the door to get help from another CNA. She stated she needed assistance with Resident #1. Interview on 2/12/26 at 2:17 PM with CNA A revealed she had worked at the facility for about 8 months. CNA A stated she was changing Resident #1 when she opened the door. She stated she was able to protect Resident #1's privacy as best as I could. CNA A stated usually she would pull the privacy curtain to the edge of the bed. She stated she never pulled the privacy curtain all the way around the bed because it was not long enough to go around the bed. CNA A stated she did not draw the curtain to cover the foot of the bed closest to the door because she did not want to expose Resident #1 to his roommate. CNA A stated she needed help with turning Resident #1 towards her so she could secure the brief around Resident #1's waist. CNA A stated Resident #1 was normally a one person assist but he was more stiff than usual. She stated he had paralysis on his left side. CNA A stated Resident #1 was not really aware of what was going on. CNA A stated if it was her or a family member lying in bed only wearing a brief, she would not like it. She stated she would probably be cold and would feel exposed to other people passing by the (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room. She stated she would not feel good about it. Observation and interview on 2/12/26 at 3:00 PM revealed Resident #1 was lying in bed connected to a G-tube. Attempted interview revealed he did not engage in conversation. Resident #1 did not speak. Interview on 2/13/26 at 6:51 PM with the DON revealed staff should ensure privacy for residents during care. The DON stated if a resident was exposed during care the resident could feel embarrassed because of being exposed. She stated it would be a violation of privacy. Review of facility policy, Quality of Life - Dignity, dated 2018 read in relevant part Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.Residents shall be treated with dignity and respect at all times.[Treated with dignity] means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments for 1 of 1 Resident (Resident #2) who was reviewed podiatry care. Nursing staff failed to ensure they cut Resident #2's toenails and/or that they referred Resident #2 to a podiatrist for care as needed. This failure could place residents at risk of experiencing pain when wearing footwear or poor hygiene. The findings were: Review of Resident #2's face sheet, dated 2/13/26, revealed he was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia (condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior) and generalized anxiety. Review of Resident #2's quarterly MDS, dated [DATE], revealed his BIMS score was 13 of 15 reflective of no cognitive impairment and he required substantial to maximum assistance with personal hygiene. Review of a local podiatry group schedule, dated 1/24/26, revealed they provided podiatry services to multiple residents in the facility. Further review revealed Resident #2 was not on the list. Review of Resident #2's physician orders for February 2026 revealed he had an order for podiatry care. Observation and interview on 2/12/26 at 11:15 AM with Resident #2 revealed he was lying in bed. He spoke very slowly and his speech was somewhat unclear but understandable. Further observation revealed Resident #2's toenails were long and about 1/2 an inch past his nailbeds. He stated he needed them cut and one of the CNA's tried to clip them but they were too thick. Resident #2 stated he preferred podiatry to do it. He stated he had not seen a podiatrist since he was admitted to the facility on [DATE]. Interview on 2/12/26 at 11:25 AM with charge nurse, LVN C revealed Resident #2 was admitted to the facility on [DATE] and had a diagnosis of Schizophrenia and Anxiety. She stated charge nurses conducted weekly skin checks and should note any problems with the residents' feet including long toenails. She stated there was nothing in Resident #2's progress notes reflecting he needed a referral to podiatry. She stated Resident #2 was not Diabetic but if his toenails were thick they would refer residents to podiatry. Observation and interview on 2/12/26 at 11:30 AM revealed Resident #2 was lying in bed. LVN C asked Resident #2 if she could look at his feet which were fully exposed. LVN C stated his toenails were about 1/2 inch past the nailbed and they needed to get cut. She stated the great toenails were very thick. She stated she would let the SW know to refer Resident #2 to podiatry. LVN C stated she had not noticed the length of his toenails before today (2/12/26). Interview on 2/12/26 at 2:00 PM with the DON revealed staff would not document the condition of a resident's long toenails on the weekly skin sheets. She stated nursing staff would report any problems during morning meetings and let the SW know when residents needed ancillary services. She stated she did not necessarily require staff to document the need for podiatry care in a progress note but expected staff to let the SW know about it so the SW could refer a resident for podiatry care. The DON stated all residents had standing orders for podiatry care. The DON stated it was important to refer the residents for podiatry care as needed for good hygiene and for dignity. She stated residents who had long toenails might also experience discomfort when they wore footwear. Interview on 2/12/26 at 3:52 PM with the SW revealed any staff working with Resident #2 could let her know he needed podiatry care. She stated she reviewed the last podiatry list of residents who were seen and Resident #2 was not seen. She stated It was important to help Resident #2 maintain good foot hygiene and if it was important to the resident then we get it done for them. The SW stated it could also be painful for Resident #2 when he wore shoes. Review of a facility (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy, Podiatry Services, undated, read It is the policy of this facility to ensure residents receive proper treatment and care within progressional standards of practice and state scope of practice, as applicable, to maintain mobility and good foot health.1. Foot care that is provided in the facility, such as toenail clipping for residents with complicating disease processes, should be provided by staff who have received education and training to provide this service.2. Residents requiring foot care who have complicating conditions will be referred to qualified professional such as a Podiatrist, Doctor of Medicine, and/or Doctor of Osteopathy.4. Employees should refer any identified need for foot care to the social worker or designee.5. The social worker or designee will assist residents in making appointments and arranging transportation to obtain needed services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and environment to help prevent the development and transmission of communicable diseases and infections for 1 of 1 Resident (Resident #1) who was reviewed for infection control. CNA A failed to wear a mask and gown while providing Resident #1, who was on EBP, with peri-care. This deficient practice could place residents at risk for contracting infectious diseases. The findings were:Review of Resident #1's admission MDS assessment, dated 1/23/26, revealed he was admitted to the facility on [DATE] with diagnoses of malnutrition, cerebral infarction (stroke) due to occlusion or stenosis (blockage/narrowing) of small artery, dysphagia (trouble swallowing) following cerebral infarction, encounter with attention to gastrostomy (enteral feeding) and cognitive communication deficit (condition where cognitive impairments, rather than language or speech problems, disrupt a person's ability to communicate effectively). Further review revealed Resident #1's BIMS score was severely cognitive impaired, he was totally dependent for all ADL care including toileting and personal hygiene, and he had a feeding tube. Review of Resident #1's Care Plan, revised on 2/6/26, read Resident #1 had Impaired Communication due to: CVA (stroke) with aphasia (trouble swallowing), cognitive communication deficit, impaired physical functioning related to cognitive impairment, debility/weakness, Hemiplegia/Hemiparesis (paralysis), neurological disease CVA (stroke), prolonged hospitalization, lack of coordination, abnormalities of gait and mobility and required 1 to 2 persons with toileting and hygiene. Further review revealed Resident #1 was on enhanced barrier precautions related to an indwelling medical device and one of the interventions read [NAME] (put on) gown and gloves during high-contact personal care activities. Observation and interview on 2/12/26 at 11:38 AM revealed CNA A came out of Resident #1's room and was not wearing gloves, a mask or a gown., There was a sign EBP (enhanced barrier precautions) and it advised staff to wear gloves, a gown and a mask when providing high contact personal care. Further observation revealed Resident #1 was lying in bed with a brief on and was connected to a G-tube. Interview on 2/12/26 at 2:17 PM with CNA A revealed she had worked at the facility for about 8 months. CNA A stated she was changing Resident #1 when she opened the door. She stated she was not wearing PPE because there was no PPE in the room or in the caddy hanging on the door or in any of the other caddies on the door nearby Resident #1's room. CNA A stated she did not mention it to any of the nurses and did not look for any on other halls or in the storage closet. CNA A stated she should have been wearing PPE while providing direct care and because Resident #1 had a peg-tube (feeding tube). CNA A stated wearing PPE would protect Resident #1 from exposure to bacteria that could infect him related to the peg-tube. She stated if he was infected it could cause him to get sick. Observation and interview on 2/11/26 at 5:22 PM with HR/Central Supply staff revealed she had been ordering supplies for about 2 years. She stated she ordered nursing supplies including PPE weekly and it was delivered the next day. She stated there was not a central supply storage room and she ordered enough PPE for a weeks time because there was not enough storage space in the facility. She stated there was a supply closet on three halls including the hall Resident #1 was located on. Observation in the supply closet where Resident #1 was located revealed 1 case and 2 individual boxes of gowns, multiple boxes of masks and gloves. HR staff stated floor staff, and resident ambassadors (staff assigned to specific resident rooms. Staff rounded on the residents in their room every morning to ensure there were no safety hazards and to ensure the residents were had everything they needed) would restock the caddies hanging on resident doors who were on EBPs. Interview on 2/12/26 at 5:32 PM with ADON B revealed she stocked up the PPE caddies earlier because the DON made a round (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and let her know the caddies were low with PPE. She stated she was the infection control preventionist and was responsible for ensuring the caddies were fully stocked. She stated some of the caddies were empty and some caddies only had a few gowns. She stated gloves were available outside most of the resident rooms. Observation and interview on 2/12/26 at 3:00 PM revealed Resident #1 was lying in bed connected to a G-tube. Attempted interview revealed he did not engage in conversation. Resident #1 did not speak. Interview on 2/13/26 at 6:51 PM with the DON revealed residents were placed on EBPs when they had an indwelling medical device or open wounds. She stated a sign was placed outside or on the resident's door informing staff and visitors of the precautions. She stated a caddy with PPE was hung on the door for the residents who were on EBPs. The DON stated the expectation was that staff wore gloves and gowns to minimize the risk of spreading infections, so residents did not contract any infections and get sick. Review of a facility policy, Enhanced Barrier Precautions, dated 6/23/25, read It is the policy of this facility to implement enhanced barrier precautions of transmission of multi-drug-resistant organisms.[Enhanced Barrier Precautions] refers to an infection control intervention designed to reduce transmission of multi-drug-resistant organisms (MDRO) that employ targeted gown and glove use during high contact resident care activities. 2. Initiation of Enhanced Barrier Precautions:b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. wounds and/or indwelling medical devices (e.g. feeding tubes) even if the resident is not known to be infected or infected with a MDRO. 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. Note: (face protection may also be needed if performing activity with risk of splash or spray (i.e. would irrigation, tracheostomy care).

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 1 of 1 Resident (Resident #3) reviewed for smoking. The facility failed to ensure Resident #3 smoked in the facility designated smoking area. Resident #3 was smoking in the front patio area of the facility. This deficient practice could place residents at risk of avoidable accidents. The findings were:Review of Resident #3's quarterly MDS, dated [DATE], revealed she was admitted to the facility on [DATE] with diagnoses including bi-polar disorder, depression, anxiety, schizophrenia and post-traumatic stress disorder. Further review revealed Resident #3 had a BIMS score of 15 of 15 reflective she did not have cognitive impairment. Review of Resident #3's initial smoking evaluation, dated 3/21/25, revealed she did not have any deficits preventing her from smoking independently and unsupervised. Further review revealed staff had reviewed the smoking policy with Resident #3 and she verbalized understanding the facility policy. Review of Resident #3's Care Plan revised 6/16/25 revealed she was a smoker, the goal was to help the resident prevent accidents while smoking and observe her for unsafe smoking behaviors or attempts to obtain smoking material from outside source. Immediately inform facility management. Observation and interview on 2/12/26 at 9AM revealed Resident #3 sitting in a wheelchair smoking a cigarette in the front patio. Resident #3 was asked if she was able to smoke in the patio. Resident #3 stated she was allowed to sign out and could smoke when she left the premises. Resident #3 was again asked if she was able to smoke in the patio and she did not answer. Further observation revealed staff entering and exiting the facility. None of the staff approached the resident. Interview on 2/13/26 at 6:51 PM with the DON revealed she was aware Resident #3 did not always follow the smoking policy. She stated she saw Resident #3 smoking in the front patio when she initially started working at the facility but had not seen her smoke in the front patio since then. The DON stated Resident #3 was only allowed to smoke in the designated resident smoking area outside in the back of the facility per policy. She stated that was where they had the metal ashtrays, fire blanket and fire extinguisher in case of a fire. The DON stated Resident #3 was a safe smoker but again should only smoke in the designated area. The DON stated Resident #3 could start a fire if she threw a cigarette butt on the ground and other residents could get hurt. The DON stated it was all staff's responsibility to ensure they were cautious and were on the lookout for residents who smoked outside of the designated areas and to report any incidents to management so they could ensure everyone's safety. Review of facility policy, Smoking policy, revised October 2023 read The facility has established and maintains safe resident smoking practices.Prior to and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. Smoking is only permitted in designated resident smoking areas, which are located outside of the building.Residents who have independent smoking privileges are permitted to keep cigarettes, electronic-cigarettes, pipes, tobacco, and other smoking items in their possession. Only disposable safety lighters are permitted.