STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and record reviews the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representatives when there was an incident involving the resident and has the potential for requiring physician intervention; a need to alter treatment for 2 of 17 Residents (Resident #1 and #2) reviewed for incident reporting. 1. The facility failed to report to Resident #1's Representative and Resident #2's Representative an incident of Resident #1 found partially disrobed in Resident #2's room on 4/14/26.2. The facility failed to report to Resident #1's Physician and Resident #2's Physician an incident of Resident #1 was found partially disrobed in Resident #2's room on 4/14/26. This failure could place residents at risk for delayed responsible party and physician's intervention.The findings included: Resident #1:A record review of Resident #1's admission record dated 4/22/2026 revealed an admission date of 11/15/2024 with a diagnosis of Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to perform simple tasks). A record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was a [AGE] year-old female admitted into the memory care unit (MCU) for long term care safety related to her cognitive impairment. Resident #1 was assessed with the inability to complete a BIMS exam but was able to make herself understood and could usually make herself understood. Resident #1 Was assessed with adequate hearing and vision and did not use glasses or hearing aids. A record review of Resident #1's care plan dated 4/22/2026 revealed Resident #1 was cared by hospice services related to senile (characteristics of old age, often referring to mental confusion, memory loss, and reduced cognitive function resulting from aging) degeneration of the brain with an intervention for staff to Keep family informed of change and condition . notify Hospice of any change in condition . Is dependent on staff for activities . social interaction . needs assistance / escort activities and functions . Has impaired physical functioning related to cognitive impairment difficulty in walking muscle weakness and lack of coordination will remain well-groomed dressed and assisted by staff as needed lower body dressing requires supervision or touching assistance. A record review of Resident #1's physicians' orders dated 4/22/2026 revealed the physician prescribed hospice services on 1/5/2025, and for nursing staff to contact hospice services to report any changes or concerns. A record review of Resident #1's nursing progress note written by RN B dated 4/14/2026 at 3:30 PM revealed an incident on 4/14/2026 at 3:30 PM During nursing shift change rounds, patient (Resident #1) was found in room (Resident #2's room) in bed A with no pants or diaper on, nude from waist down and covered with a blanket. Patient that resides in that room was sitting on his walker on the other end of the room looking out the window. Asked both patients what was going on, both said they don't know. (Resident #1) orientated x 1 to person only. Male patient stepped out of room at this time, and Resident #1 was dressed and checked, no abnormal findings noted, she denies anything happened and feels fine. Patient was re-orientated and shown where her room is. Will continue to monitor patient's behavior. A record review of Resident #1's medical records for the period of 4/14/2026 through 4/22/2026 revealed no report to the resident's physician or families for (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2026
NAME OF PROVIDER OR SUPPLIER San Antonio West Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the 4/14/2026 incident where Resident #1 was discovered semi-nude in Resident #2's room. During an interview on 4/22/2026 at 12:10 PM Resident #1's Representative stated Resident #1 had dementia and lived in the MCU and was very confused. Resident #1's Representative stated on 4/21/2026 he received a report from the hospice RN that on 4/14/2026 Resident #1 was found in Resident #2's room nude from the waist down. Resident #1's Representative stated he was upset to learn of the incident a week later and felt he should have been given a report immediately. Resident #1's Representative stated he was in the facility after 4/14/2026 and had met with the SW and the ADON on 4/15/2026, a day after the incident and they did not report the incident Resident #2:A record review of Resident #2's admission record dated 4/22/2026 revealed an admission date of 2/10/2026 with a diagnosis of severe dementia (a general, umbrella term for a progressive decline in mental ability, including memory, thinking, and reasoning, severe enough to interfere with daily life) and anxiety. A record review of Resident #2's admission MDS assessment dated [DATE] revealed Resident #2 was a [AGE] year-old male admitted for LTC in the MCU. Resident #2 was assessed with adequate hearing without a hearing aid and adequate vision with the use of glasses. Resident #2 was assessed with the ability to have clear speech, could usually understand others and could usually make himself understood. Resident #2 was assessed with a BIMS score of 3 out of a possible 15 which indicated severe cognitive impairment. A record review of Resident #2's medical records for the period of 4/14/2026 through 4/22/2026 revealed no report to the resident's physician or families for the 4/14/2026 incident where Resident #1 was discovered semi-nude in Resident #2's room. During an interview on 4/22/2026 at 4:08 PM Resident #2's Representative stated she had not received a report from the facility for an incident on 4/14/2026. During an interview on 4/22/2026 at 1:13 PM RN B stated on 4/14/2026 she worked the 2:00 PM to 10:00 PM shift in the MCU and was receiving a report from LVN D who had worked the 6:00 AM shift to 2:00 PM shift in the MCU. RN B stated during the report LVN D could not locate Resident #1 and they began looking for Resident #1. RN B stated they located Resident #1 in Resident #2's room semi-nude from the waist down. RN B stated she assessed both residents without injuries and assisted Resident #1 to dress and redirected her back to her room. RN B stated she reported the incident to the DON and the ADON During an interview on 4/22/2026 at 12:00 PM the ADON stated she was the supervisor for the MCU. The ADON stated she worked on 4/14/2026 and had received a report from RN B that Resident #1 was found in Resident #2's room semi-nude. The ADON stated she and the SW met with Resident #1's Representative on 4/15/2026 to discuss moving Resident #1 out of the MCU but had not reported to Resident #1's Representative the incident on 4/14/2026 where the resident was found semi-nude in Resident #2's room. The ADON stated that because it was a sensitive subject, they had not gone over the details with Resident #1's Representative, and because their belief was RN B had already reported the incident to Resident #1's and resident #2's respective representatives. The ADON further stated she believed RN B had also reported the incident to the residents' physician but had not verified if they had done so. During an interview on 4/22/2026 at 1:10 PM Hospice RN C stated she spoke with Resident #1's Representative on 4/21/2026 at 11:40 AM and gave a report of the 4/14/2026 incident where Resident #1 was semi-nude in another male resident's room. Hospice RN C stated she believed Resident #1's Representative had received a report from the facility's RN who discovered Resident #1 In the male resident's room. Hospice RN C stated she visited Resident #1 weekly on Thursdays and on 4/16/2026 she learned of the 4/14/2026 incident from staff. Hospice RN C stated when she spoke to Resident #1's Representative on 4/21/2026 and she realized Resident #1's Representative had not received a report of the incident. During an interview on 4/24/2026 at 3:00 PM the Administrator and the DON stated the expectation for nursing staff was to report all unusual incidents to the Residents' representatives and physicians as soon as an incident occurred. The Administrator and the DON stated the potential negative outcome for residents could be not being informed of their health status and not having the interventions of their physicians. A record review of the facility's policy titled Notification of Changes dated 6/23/2025, revealed, Policy: the purpose of this policy is to ensure the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility promptly informs the resident, consult the residence physician: and notifies, consistent with his or her authority, the residence representative when there is a change requiring notification. Circumstances requiring notification include: . residents incapable of making decisions: the representative would make any decision that have to be made. The resident should still be told what is happening to him or her.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to report all alleged violations involving abuse, neglect, exploitation or mistreatment, were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures, for 2 of 17 (Residents #1 and #2) residents reviewed for reporting. The facility failed to report to the state agency alleged incident of Resident #1 found partially disrobed in Resident #2's room. This failure could place residents at risk for not having allegations of ANE reported.The findings included: Resident #1:A record review of Resident #1's admission record dated 4/22/2026 revealed an admission date of 11/15/2024 with a diagnosis of Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to perform simple tasks). A record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was a [AGE] year-old female admitted into the memory care unit (MCU) for long term care safety related to her cognitive impairment. Resident #1 was assessed with the inability to complete a BIMS exam but was able to make herself understood and could usually make herself understood. Resident #1 Was assessed with adequate hearing and vision and did not use glasses or hearing aids. A record review of Resident #1's care plan dated 4/22/2026 revealed Resident #1 was cared by hospice services related to senile (characteristics of old age, often referring to mental confusion, memory loss, and reduced cognitive function resulting from aging) degeneration of the brain with an intervention for staff to Keep family informed of change and condition . notify Hospice of any change in condition . Is dependent on staff for activities . social interaction . needs assistance / escort activities and functions . Has impaired physical functioning related to cognitive impairment difficulty in walking muscle weakness and lack of coordination will remain well-groomed dressed and assisted by staff as needed lower body dressing requires supervision or touching assistance. A record review of Resident #1's physicians' orders dated 4/22/2026 revealed the physician prescribed hospice services on 1/5/2025, and for nursing staff to contact hospice services to report any changes or concerns. A record review of Resident #1's nursing progress notes revealed an incident on 4/14/2026 at 3:30 PM where Resident #1 was found in male Resident #2's room, sitting on his bed nude from the waist down while fully clothed Resident #2 was in the room with the door closed. RN B documented, During nursing shift change rounds, patient (Resident #1) was found in room (Resident #2's room) in bed A with no pants or diaper on, nude from waist down and covered with a blanket. Patient that resides in that room was sitting on his walker on the other end of the room looking out the window. Asked both patients what was going on, both said they don't know. (Resident #1) orientated x 1 to person only. Male patient stepped out of room at this time, and Resident #1 was dressed and checked, no abnormal findings noted, she denies anything happened and feels fine. Patient was re-orientated and shown where her room is. Will continue to monitor patient's behavior. Resident #2:A record review of Resident #2's admission record dated 4/22/2026 revealed an admission date of 2/10/2026 with a diagnosis of severe dementia (a general, umbrella term for a progressive decline in mental ability, including memory, thinking, and reasoning, severe enough to interfere with daily life) and anxiety. A record review of Resident #2's admission MDS assessment dated [DATE] revealed Resident #2 was a [AGE] year-old male admitted for LTC in the MCU. Resident #2 was assessed with adequate hearing without a hearing aid and adequate vision with the use of glasses. Resident #2 was assessed with the ability to have clear speech, could usually (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	understand others and could usually make himself understood. Resident #2 was assessed with a BIMS score of 3 out of a possible 15 which indicated severe cognitive impairment. A record review of Resident #2's nursing progress notes written by LVN F documented on 3/31/2026 at 7:42 PM that, Resident #2 was verbally aggressive towards when (Resident #1) was taken to room for care resident states She is mine and will do whatever i say Nurse redirected resident that care needed to be provided as (Resident #1) started to cry. Nurse reassured (Resident #1) she was safe and everything was okay. A record review of the Texas Unified Licensure Information Portal (TULIP) website database; accessed 4/22/2026; for the period between 3/1/2026 and 4/22/2026, revealed no reported suspicions / allegations regarding Resident #1 and Resident #2's suspected ANE. During an interview on 4/22/2026 at 12:00 PM the ADON stated she was the supervisor for the MCU. ADON stated she worked on 4/14/2026 and had received a report from RN B that Resident #1 was found in Resident #2's room semi-nude. The ADON stated she had reported the incident to the DON and the Administrator who was the abuse prevention coordinator. During an interview on 4/22/2026 at 1:13 PM RN B stated on 4/14/2026 she worked the 2:00 PM to 10:00 PM shift in the MCU RN B stated during the report LVN D could not locate Resident #1 and they began looking for Resident #1. RN B stated they located Resident #1 in Resident #2's room semi-nude from the waist down. RN B stated she assessed both residents without injuries and assisted Resident #1 to dress and redirected her back to her room. RN B stated she had reported the incident to the DON and the ADON. During an interview on 4/22/2026 at 1:20 PM LVN D and CNA E stated they were on duty from 6:00 AM - 2:00 PM on 4/14/2026 when around 2:00 PM LVN D recognized Resident #1 was not in the Livingroom where she usually sat and LVN D went to Resident #1's room and discovered Resident #1 was not in her room. LVN D immediately suspected Resident #1 was in Resident #2's room and directly went to Resident #2's room where Resident #1 was found nude from the waist down seated on the side of Resident #2's bed. LVN D called out to CNA E who entered the room and observed Resident #2 coming out of the bathroom dressed and asking, what's going on. During an interview on 4/24/2026 at 3:00 PM the Administrator and the DON stated they had not received a report of the 3/31/2026 incident of Resident #2 being verbally aggressive towards Resident #1 but had received a report of the 4/14/2026 incident in the MCU where Resident #1 was semi-nude in Resident #2's room. The Administrator and the DON stated they had not reported the incidents to the state agency and regarding the 4/14/2026 incident they believed it was normal behavior for residents who are confused to wander about the MCU and could be confused and disrobe. The Administrator and the DON stated they believed that nothing happened between Resident #1 and Resident #2 and therefore did not consider the incident a suspicion of ANE. A record review of the facility's policy undated abuse, neglect, and exploitation policy revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Reporting / response: the facility will have written procedures that include: reporting of all alleged violations to the Administrator, state agency, adult Protective Services and to all other required agencies within specified time frames: a) immediately, but no later than two hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, orb) not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury. A record review of the facility's policy, undated, abuse, neglect, and exploitation policy revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Investigation of alleged abuse, neglect, and exploitation; an immediate investigation is warranted when suspicion of abuse, neglect, for exploitation, poor reports of abuse, neglect, or exploitation occur.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to have evidence that all alleged violations are thoroughly investigated, prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress, report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, for 2 of 17 Residents (Resident #1 and Resident #2) reviewed for facility investigations. The facility failed to investigate allegations of incident of Resident #1 found partially disrobed in Resident #2's room. This failure could place residents at risk for not having allegations of ANE investigated and summary reported.The findings included: Resident #1:A record review of Resident #1's admission record dated 4/22/2026 revealed an admission date of 11/15/2024 with a diagnosis of Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to perform simple tasks). A record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was a [AGE] year-old female admitted into the memory care unit (MCU) for long term care safety related to her cognitive impairment. Resident #1 was assessed with the inability to complete a BIMS exam but was able to make herself understood and could usually make herself understood. Resident #1 Was assessed with adequate hearing and vision and did not use glasses or hearing aids. A record review of Resident #1's care plan dated 4/22/2026 revealed Resident #1 was cared by hospice services related to senile (characteristics of old age, often referring to mental confusion, memory loss, and reduced cognitive function resulting from aging) degeneration of the brain with an intervention for staff to Keep family informed of change and condition . notify Hospice of any change in condition . Is dependent on staff for activities . social interaction . needs assistance / escort activities and functions . Has impaired physical functioning related to cognitive impairment difficulty in walking muscle weakness and lack of coordination will remain well-groomed dressed and assisted by staff as needed lower body dressing requires supervision or touching assistance. A record review of Resident #1's physicians' orders dated 4/22/2026 revealed the physician prescribed hospice services on 1/5/2025, and for nursing staff to contact hospice services to report any changes or concerns. A record review of Resident #1's nursing progress notes revealed an incident on 4/14/2026 at 3:30 PM where Resident #1 was found in male Resident #2's room, sitting on his bed nude from the waist down while fully clothed Resident #2 was in the room with the door closed. RN B documented, During nursing shift change rounds, patient (Resident #1) was found in room (Resident #2's room) in bed A with no pants or diaper on, nude from waist down and covered with a blanket. Patient that resides in that room was sitting on his walker on the other end of the room looking out the window. Asked both patients what was going on, both said they don't know. (Resident #1) orientated x 1 to person only. Male patient stepped out of room at this time, and Resident #1 was dressed and checked, no abnormal findings noted, she denies anything happened and feels fine. Patient was re-orientated and shown where her room is. Will continue to monitor patient's behavior. Resident #2:A record review of Resident #2's admission record dated 4/22/2026 revealed an admission date of 2/10/2026 with a diagnosis of severe dementia (a general, umbrella term for a progressive decline in mental ability, including memory, thinking, and reasoning, severe enough to interfere with daily life) and anxiety. A record review of Resident #2's admission MDS assessment dated [DATE] revealed Resident #2 was a [AGE] year-old male admitted for LTC in the MCU. Resident #2 was assessed with adequate hearing without a hearing aid and adequate vision with the use of glasses. Resident #2 was assessed with the ability to have clear speech, could usually understand others and could usually make himself understood. Resident #2 was assessed with a BIMS score of 3 out of a possible 15 which indicated severe cognitive impairment. During an interview on 4/22/2026 at 12:00 PM the ADON stated she was the supervisor for the MCU. ADON stated she (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	worked on 4/14/2026 and had received a report from RN B that Resident #1 was found in Resident #2's room semi-nude. The ADON stated she had reported the incident to the DON and the Administrator who was the abuse prevention coordinator. During an interview on 4/22/2026 at 1:13 PM RN B stated on 4/14/2026 she worked the 2:00 PM to 10:00 PM shift in the MCU and was receiving a report from LVN D who had worked the 6:00 AM shift to 2:00 PM shift in the MCU. RN B stated during the report LVN D could not locate Resident #1 and they began looking for Resident #1. RN B stated they located Resident #1 in Resident #2's room semi-nude from the waist down. RN B stated she assessed both residents without injuries and assisted Resident #1 to dress and redirected her back to her room. RN B stated she had reported the incident to the DON and the ADON. During an interview on 4/24/2026 at 3:00 PM the Administrator and the DON stated they had not received a report of the 3/31/2026 incident of Resident #2 being verbally aggressive towards Resident #1 but had received a report of the 4/14/2026 incident in the MCU where Resident #1 was semi-nude in Resident #2's room. The Administrator and the DON stated they had not provided the state agency an investigation summary report for the 4/14/2026 incident they believed it was normal behavior for residents who are confused to wander about the MCU and could be confused and disrobe. The Administrator and the DON believed that nothing happened between Resident #1 and Resident #2 and therefore did not consider the incident a suspicion of ANE. A record review of the facility's policy, undated abuse, neglect, and exploitation policy revealed, . Investigation of alleged abuse, neglect, and exploitation; an immediate investigation is warranted when suspicion of abuse, neglect, for exploitation, or reports of abuse, neglect, or exploitation occur.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, interviews, and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment. The comprehensive care plan must describe the following; the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and the services provided or arranged by the facility, as outlined by the comprehensive care plan, must be culturally-competent and trauma-informed, for 2 of 17 Residents (Resident #1 and Resident #2) reviewed for comprehensive care plans. The facility failed to have interventions care planned in regard to Resident #2's unwanted focused attention towards Resident #1. These failures could place residents at risk for not having their highest practicable physical, mental, and psychosocial well-being needs care met. The findings included: Resident #1:A record review of Resident #1's admission record dated 4/22/2026 revealed an admission date of 11/15/2024 with a diagnosis of Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to perform simple tasks). A record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was a [AGE] year-old female admitted into the memory care unit (MCU) for long term care safety related to her cognitive impairment. Resident #1 was assessed with the inability to complete a BIMS exam but was able to make herself understood and could usually make herself understood. Resident #1 Was assessed with adequate hearing and vision and did not use glasses or hearing aids. A record review of Resident #1's care plan dated 4/22/2026 revealed Resident #1 had no specific interventions regarding Resident #2's unwanted focused attention. A record review of Resident #1's physicians' orders dated 4/22/2026 revealed the physician prescribed hospice services on 1/5/2025, and for nursing staff to contact hospice services to report any changes or concerns. During an interview on 4/22/2026 at 12:10 PM Resident #1's Representative stated Resident #1 had dementia and lived in the MCU and was very confused. Resident #1's Representative stated he visited Resident #1 often usually 5 times a week if not daily. Resident #1's Representative stated he learned, over Resident #1's stay, that Resident #2 had become fond of Resident #2 and had developed a habit of having Resident #2 sit next to him. Resident #1's Representative stated the staff had reported this behavior to him and he had observed the same behavior. Resident #1's Representative stated he had often visited and physically removed Resident #1 from Resident #2's area. Resident #2:A record review of Resident #2's admission record dated 4/22/2026 revealed an admission date of 2/10/2026 with a diagnosis of severe dementia (a general, umbrella term for a progressive decline in mental ability, including memory, thinking, and reasoning, severe enough to interfere with daily life) and anxiety. A record review of Resident #2's admission MDS assessment dated [DATE] revealed Resident #2 was a [AGE] year-old male admitted for LTC in the MCU. Resident #2 was assessed with adequate hearing without a hearing aid and adequate vision with the use of glasses. Resident #2 was assessed with the ability to have clear speech, could usually understand others and could usually make himself understood. Resident #2 was assessed with a BIMS score of 3 out of a possible 15 which indicated severe cognitive impairment. A record review of Resident #2's care plan dated 4/22/2026, revealed Resident #2 had socially inappropriate behaviors Resident #2's care plan revealed generic interventions to Document specific instances of inappropriate behavior, including the context, duration, an impact on others, 4/16/2026. Further review revealed there was no care plan specific for Resident #2's focused attention towards Resident #1. A record review of Resident #2's nursing progress notes revealed LVN F documented on 3/31/2026 at 7:42 PM documented, Resident verbally aggressive towards when (Resident #1) was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2026
NAME OF PROVIDER OR SUPPLIER San Antonio West Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	taken to room for care resident states She is mine and will do what ever I say Nurse redirected resident that care needed to be provided as (Resident #1) started to cry. Nurse reassured (Resident #1) she was safe and everything was okay. During an interview on 4/22/2026 at 4:08 PM Resident #2's Representative stated she had received a report from the facility for an incident where Resident #2 had been aggressive towards peer residents and believed these aggressive incidents were being addressed by staff to redirect Resident #2 to safety. During a joint interview on 4/22/2025 at 1:20 PM LVN D and CNA E stated LVN D stated Resident #2 had been admitted about 3 months ago and Resident #1 had been a resident for longer. CNA E and LVN D stated Resident #2 had become increasingly focused on Resident #1 over the last month and had a behavior of scolding Resident #1 when he perceived she was not fast enough and had been known to cuss at Resident #1. LVN D and CNA E stated they monitored Resident #2 and Resident #1 and would intervene for safety by redirecting Resident #1 or Resident #2 away from each other. LVN D stated Residents #1 and Resident #2 did not have a revised care plan to detail the staffs' interventions to monitor and redirect Resident #1 and Resident #2 away from each other. During an interview on 4/24/2026 at 3:00 PM the Administrator and the DON stated the expectation for nursing staff was to report all unusual incidents and their monitoring and interventions to the IDT as soon as the interventions occurred so that a revised care plan could be developed. The Administrator and the DON stated the potential negative outcome for residents could be not having an accurate care plan. A record review of the facility's undated care plan policy revealed, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Comprehensive care plans may include but are not limited to resident Kardex records, baseline care plans, and task listings.The comprehensive care plan will describe the following -The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; and .The residents' goals for admission and desired outcomes.Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the residents' medical, physical, mental and psychosocial needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2026
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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide or obtain laboratory services that meet the needs of its residents, for 1 of 3 residents (Resident #4) reviewed for laboratory services, in that: LVN G failed to obtain a urinary analysis for resident #4 as prescribed by NP H. This failure could place residents at risk for delayed treatment.Based on interviews and record reviews, the facility failed to provide or obtain laboratory services that meet the needs of its residents, for 1 of 3 residents (Resident #4) reviewed for laboratory services, in that;. LVN G failed to obtain a urinary analysis for resident #4 as prescribed by NP H. This failure could place residents at risk for delayed treatment. The findings included: A record review of Resident #4's admission record dated 4/24/2026 revealed an admission date of 1/8/2025 and a discharge date of 4/18/2026 with diagnoses which included history of falling, hemiparesis following cerebral infarction affecting left side (left side paralysis after a stroke), and type II diabetes (long term disease where the body cannot produce enough insulin or cannot use the insulin it does produce). A record review of Resident #4's quarterly MDS assessment dated [DATE] revealed Resident #4 was a [AGE] year-old female admitted for LTC and was assessed with a BIMS score of 3 out of a possible 15 which indicated sever cognitive impairment. A record review of Resident #4's care plan dated 4/24/2026 revealed Resident #4 was incontinent of bladder and had nursing interventions to monitor for signs and symptoms of urinary tract infections (UTI) as well as a history of falls and had interventions for urinary analyses, Resident #4) has actual fall 04/07/2026 Actual Fall no injury . Date Initiated: 04/07/2026. Labs and UA to be collected Date Initiated: 04/08/2026. A record review of Resident #4's Physician's orders dated 4/24/2026 revealed no orders for a urinary analysis for the period reviewed 4/1/2026 through 4/24/2026. A record review of Resident #4's nursing progress note written by LVN G documented on 4/8/2026 at 11:20 AM that NP H Ordered CBC (a blood laboratory report for blood cells) and UA (a laboratory report for urine) per (NP H) as part of action plan for recent fall. During an interview on 4/22/2026 at 5:17 PM NP H stated she was the nurse practitioner for Resident #4 and had been following her for a history of UTI's and cardiac disease. NP H stated she could not recall the report from LVN G about Resident #4's fall but could state it would be reasonable for her to order a CBC and UA laboratory report to assess Residents for potential infections and possible rational for falls. During an interview on 4/22/2026 at 6:00 PM LVN G stated she had spoken with NP H when Resident #4 was reviewed for her fall on 4/8/2026. LVN G stated NP H requested a CBC laboratory report and LVN G coordinated and secured the lab draw. LVN G stated although her note documented that nurse practitioner wanted a blood draw and a urinary analysis her note was not complete and stated the note should have read NP H wanted the blood draw, however, the urinary analysis was only to take place if Resident #4 had signs and symptoms of a potential UTI; for example, confusion, pain with urination, foul smelling urine, and therefore the order for UA was never in place and it was never completed. During a joint interview on 4/24/2026 at 11:07 AM the DON and the Administrator stated the expectation was for nurses to support and implement prescribers' new orders for residents and stated LVN G was responsible for coordinating NP H's order for a urinary analysis and had not done so. The DON stated the potential negative outcome could be prescribers would be NP's and physicians would be denied the opportunity to intervene by not having laboratory services reported. A policy was requested for the incident, and the DON and the Administrator stated the facility followed HHSC guidelines.