

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

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No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>675002                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>06/18/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>San Antonio West Nursing and Rehabilitation                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>636 Cupples Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      |                                                 |
| F 0925<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Many                        | <p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program so that the facility is free of pests for 1 of 1 facility reviewed for physical environment. The facility failed to ensure the facility was free from flies. These failures could lead to cross contamination and/or decreased quality of life. Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program so that the facility is free of pests for 1 of 1 facility reviewed for physical environment. The facility failed to ensure the facility was free from flies. These failures could lead to cross-contamination and/or decreased quality of life. Findings included: Record review of the facility's pest control invoice, dated 1/2/26, revealed that single bulb for fly light was replaced. During observation and interview on 6/17/26 beginning at 11:24 am, seven flies were observed in the kitchen, flying over the hot table where the lunch meal was being prepared. The DM said pest control went to the facility every couple of weeks and PRN. The DM further stated that there was an electric fly swatter in the office. The DM said the residents went in and out to the patio for smoke breaks and flies kept entering the facility. The DM said there was also an air curtain on the back door of the kitchen, but the front door kept opening and closing allowing flies to enter the kitchen, especially after it rained. The DM said if flies touched the food it had to be tossed because it could make somebody sick. During observation and interview on 6/17/26 at 12:53 pm, a fly was observed in Resident #5's room. Resident #5 said he had killed 3-4 flies. Resident #5 further stated it bothered him when flies landed on his food. During observation on 6/17/26 at 12:55 pm, a fly was observed on the B hall. During observation and interview on 6/17/26 at 12:59 pm, nine flies were observed on three plates of leftover food on a table in the dining room. Resident #10 was observed swatting flies away from her face. Resident #10 said the flies bothered her, especially when she was trying to eat. Resident #9 said the flies bothered her when they got in her face. Resident #9 further stated that the flies got on the food. During observation on 6/17/26 at 1:04 pm, 3 flies were observed on the D hall. During an interview on 6/17/26 at 1:06 pm, Resident #8 was sitting in the dining room. He said the flies were in his face. During observation on 6/17/26 at 1:56 pm, 2 flies were observed in Resident #4's room. During observation and interview on 6/17/26 at 2:30 pm, a fly was observed in Resident #2's room. During an interview on 6/17/26 at 2:55 pm, Resident #6 said flies came into the facility now and then. During an interview on 6/17/26 at 3:48 pm, Resident #1 said sometimes flies landed on his food, so he had to eat quickly. Record review of the facility's pest control invoice, dated 6/17/26, revealed that the fly boards in all fly light stations were changed out. During observation and interview on 6/18/26 at 8:17 am, six flies were observed on dirty dishes on a cart outside the kitchen. Further observation revealed four flies on dirty dishes on a second cart outside the kitchen. LVN A confirmed there were flies on the dirty dishes on the carts outside the kitchen. During an interview on 6/18/26 at 8:30 am, LVN B said she had recently noticed that flies had been an issue. During an interview on 6/18/26 at 8:48 am, the MS said pest control was scheduled to go to the facility once a week, and they checked all the fly traps. During an interview on 6/18/26 at 11:39 am, the Administrator said she was responsible for ensuring the facility was free of flies. The Administrator further stated pest control went to the facility every two weeks and PRN. Record review of the facility's policy titled Pest control, revised May 2008, revealed: .Our facility shall (continued on next page)</p> |                                                                                      |                                                 |

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.

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|--------------------------------------------------------------------------|-------|-----------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|--------------------------------------------------------------------------|-------|-----------|

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>675002                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>06/18/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>San Antonio West Nursing and Rehabilitation                                                    |                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>636 Cupples Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                 |                                                                                      |                                                 |
| F 0925<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Many                        | maintain an effective pest control program.1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects. Record review of the facility's policy titled Safe and Homelike Environment, Copyright 2025, revealed: .In accordance with residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment. |                                                                                      |                                                 |