

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/10/2026
NAME OF PROVIDER OR SUPPLIER San Antonio West Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 636 Cupples Rd San Antonio, TX 78237	
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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure incontinent care was provided in accordance with appropriate treatment and service practices to prevent urinary tract infections and to restore continence to the extent possible for 1 of 1 resident (Resident #1) reviewed for incontinent care and catheter care, in that: While providing incontinent care for Resident #2, CNA B used a back to front motion to clean Resident #2. This deficient practice could place residents at-risk for infection and skin break down due to improper care practices. The findings were: Record review of Resident #2's face sheet, dated 07/07/2026, revealed an admission date of 09/25/2025, with a diagnosis of Hemiplegia (severe paralysis on one side of the body. Record review of Resident #2's Quarterly MDS assessment, dated 06/14/2026, revealed the resident had a BIMS score of 03, which indicated severe cognitive impairment, and he was always incontinent of bowel and bladder. Record review of Resident #2s care plan, dated 10/29/2025, with a problem of Incontinent of bladder related to functional incontinence. and an intervention of Provide proper perineal care and use barrier creams to protect the skin from urine/feces exposure. Observation on 07/08/2026 at 9:56 a.m. revealed CNAs A and B provided incontinent care for Resident #2. During care CNA B used a back and forth motion to wipe the resident instead of a front to back motion. She wiped Resident #2's penis from base to tip instead of tip to base. During an interview with CNA B on 07/08/2026 at 10:10 a.m., CNA B stated the proper motion to clean a resident's penis was front to back or tip to base. She did not realize she was using the wrong motion and stated she was nervous. She stated she received training in incontinent care within the year from the DON and ADON. During an in interview with the DON on 07/08/2026 at 2:30 p.m., she stated the correct motion to clean a resident was front to back to prevent the contamination of the urinal tract with fecal matter and prevention of infection. She stated the staff was provided incontinent care training, and their skills were checked annually and as needed. Record review of facility's policy titled, Perineal care, dated 2018, revealed, For a male resident:a.Wet washcloth and apply soap or skin cleansing agent.b.Wash perineal area starting with urethra and working outward.		

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 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 comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1 of 5 residents (Resident #7) reviewed for infection control, in that: The facility failed to ensure CNA B changed her gloves and sanitized her hands after cleaning Resident #2 and before touching the clean brief and used the proper technique to sanitize her hands. These failures could place residents at-risk for infection due to improper care practices. The findings were: Record review of Resident #2's face sheet, dated 07/07/2026, revealed an admission date of 09/25/2025, with a diagnosis of Hemiplegia (severe paralysis on one side of the body), osteoarthritis (joint pain that comes with wear and tear. Record review of Resident #2's Quarterly MDS assessment, dated 06/14/2026, revealed the resident had a BIMS score of 03, which indicated severe cognitive impairment, and he was always incontinent of bowel and bladder. Record review of Resident #2s care plan, dated 10/29/2025, with a problem of Incontinent of bladder related to functional incontinence. and an intervention of Provide proper perineal care and use barrier creams to protect the skin from urine/feces exposure. Observation on 07/08/2026 at 9:56 a.m. revealed while providing incontinent care for Resident #2, CNA B did not sanitize between her fingers while using the sanitizer between change of gloves after cleaning Resident's genitals. CNA B did not change her gloves and sanitize her hands after cleaning the resident's buttocks and before touching the clean brief. During an interview on 07/08/2026 at 10:10 a.m. with CNA B, she stated she did not realize she was not sanitizing between her fingers when using the sanitizer and thought she was. Further interview revealed she stated she did not change her gloves and sanitize her hands after cleaning Resident #2's buttocks and before touching the clean brief. She said she was nervous and forgot. She stated she received infection control training within the year. Interview on 07/08/2026 at 2:30 p.m. with the DON, revealed she stated the staff needed to sanitize between their fingers when using the sanitizer and, needed to sanitize hands between change of gloves and change gloves between cleaning a resident and touching something clean for the prevention of infection to the residents but also the staff. The DON stated infection control training was provided and skills were checked annually. Review of facility's policy, titled Handwashing/Hand Hygiene , dated 2018, revealed Facility staff and volunteers must perform hand hygiene procedures in the following circumstances including but not limited to [.] after removing personal protective equipment [.] Use an alcohol-based hand rub [.] before moving from a contaminated body site to clean body site during resident care [.] after contact with bodily fluid [.] Using alcohol-Based hands rubs 1. Apply generous amount of product to palm of hands and rub hands together. 2. Cover all surfaces of hands and fingers until hands are dry.		

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. Based on observation, interview, and record review, the facility failed to ensure residents have a right to personal privacy for 1 of 2 residents (Resident #2) reviewed for resident rights, in that: CNAs A and B did not completely close Resident #2's privacy curtain while providing incontinent care for the resident. This deficient practice could place residents who received incontinent care at-risk of loss of dignity, embarrassment, and a decline in quality of life. Findings include: Record review of Resident #2's face sheet, dated 07/07/2026, revealed an admission date of 09/25/2025, with diagnoses that included: Aphasia (disorder of language because of injury to the brain), Hemiplegia (severe paralysis on one side of the body), osteoarthritis (joint pain that comes with wear and tear), Depression (mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #2's Quarterly MDS assessment, dated 06/14/2026, revealed the resident had a BIMS score of 03, which indicated severe cognitive impairment, and he was always incontinent of bowel and bladder. Record review of Resident #2s care plan, dated 10/29/2025, with a problem of Incontinent of bladder related to functional incontinence. and an intervention of Provide proper perineal care and use barrier creams to protect the skin from urine/feces exposure. Observation on 07/08/2026 at 9:55 a.m. revealed CNAs A and B provided incontinent care for Resident #2. During care CNAs A and B did not completely pull the curtain at left side of the bed to offer privacy to the resident because the privacy curtain was too short to surround the bed. Further observation revealed Resident #2 could have been seen by someone opening the room's door and his genitals were fully exposed. During an interview with CNAs A and B on 07/08/2026 at 10:10 a.m., CNAs A and B stated the privacy curtain was not closed while they provided care for Resident #2 but should have been. The stated they had reported the curtain was too short. CNAs A and B stated they had received resident rights training from DON and ADON. During an interview with the DON on 07/08/2026 at 2:35 p.m., she stated privacy must be provided during nursing care and Resident #2's privacy curtain should have been closed completely. They stated Resident rights training had been provided for the staff within the current year. Record review of the facility's policy titled, Quality of life - Dignity dated 2018, revealed, Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedure.		