

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2025
NAME OF PROVIDER OR SUPPLIER Crestway Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 7181 Crestway Dr San Antonio, TX 78239	

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. (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: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/02/2025
NAME OF PROVIDER OR SUPPLIER Crestway Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 7181 Crestway Dr San Antonio, TX 78239	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to notify, consistent with his or her authority, the resident representative(s) when there was a significant change in the resident's physical, mental, or psychosocial status for one (Resident #1) of five residents reviewed for notification of changes. The facility failed to notify Resident #1's family when she expired (died) on [DATE]. This failure could result in the resident's family/RP not being aware of the resident's condition. The findings included: Record review of Resident #1's face sheet dated [DATE] revealed an [AGE] year-old female, admitted on [DATE] and readmitted on [DATE] with diagnoses which included displaced fracture of seventh cervical vertebra, subsequent encounter for fracture with routine healing (a break in the small bones of the neck that was healing), hypertension (elevated blood pressure) and anxiety disorder. The face sheet indicated Resident #1 was discharged on [DATE] (location not specified). Record review of Resident #1's admission MDS assessment dated [DATE] revealed a BIMS score of 3 which indicated a severe cognitive impairment with partial to substantial assistance required for ADL. Record review of Resident #1's discharge MDS assessment dated [DATE] revealed the resident died in the facility on [DATE]. Record review of Resident #1's General Progress Note dated [DATE] revealed facility staff conducted CPR on the resident until EMS arrived and took over. Time of death was called at 12:02 p.m. ([DATE]) and police arrived to assess scene. Record review of Resident #1's General Progress Note dated [DATE] by the DON indicated the physician was notified of local police arrival (at the facility) and ongoing investigation. Nursing staff instructed by police to not speak with residents, enter room or contact families. During an interview on [DATE] at 1:05 p.m., the ADON stated police conducted an investigation of the death of Resident #1 because another resident saw Resident #1 fall to the floor and thought he saw her roommate hitting her with a croc (a type of foam shoe) or a purse. The ADON stated the facility had conducted an investigation and no other residents or staff heard or saw anything. She stated because the police were involved in the death investigation, they (police) told them (facility staff) that they were not allowed to notify the family of Resident #1 of her death. She stated the police told the management in a group. She stated she was in the office, as well as the DON and Administrator. The ADON stated because they had been told not to tell the family due to the investigation, the family was not notified of Resident #1's death. She stated on [DATE] the family called to check on Resident #1. The ADON stated she took the call and confirmed she died but was not able to offer any other details. She stated she gave the family the phone number of the police officer and told them to call the police for additional information. The ADON stated the family was very upset about it. During an interview on [DATE] at 1:54 p.m., the DON stated on [DATE], she received a call that Resident #1 had fallen, and as they were getting her back in bed, she coded. She stated another resident approached EMS personnel as they were attempting to resuscitate the resident and stated he saw another resident hit her with a shoe. The DON stated this resulted in a police investigation. She stated the results of the investigation after an autopsy was complete was that Resident #1 died as a result of a clot in her lungs. Attempted interview on [DATE] at 2:45 p.m. with the family of Resident #1. No return call was received. During an interview on [DATE] at 3:41 p.m., the local police department investigator stated he told the facility staff they were not to notify Resident #1's family of her death due to the investigation. He stated sternly, it was the local law enforcement responsibility to notify next of kin, not the facilities. During an interview on [DATE] at 4:07 p.m., the DON stated they had asked the police officer if they were okay to notify the family of Resident #1 of her death. She stated the police officer told her, the ADON and Administrator who were all in the office together no. The DON stated he said, don't notify family. The DON stated the police officer stated they would get the medical examiner report first because it was a crime scene and they needed to talk (interview) the family first. The DON stated she did not specifically notify the police officer of their requirements to notify the family of a change of condition. She stated during the investigation itself, facility policy had come up because the police officer originally told them they could not investigate. The DON stated she told the police officer it was their policy to investigate, and he had replied that the police were doing the investigation. The DON stated after the police left the facility conducted their own investigation. The DON stated their policy stated family should be notified timely. She stated she as well as other facility staff wanted to notify them right then and there. She stated they wanted to make sure the important things were completed. She stated because she was unable to do it, she documented it in Resident #1's medical record. During an interview on [DATE] at 4:15 p.m. the Administrator stated an investigator with the local police</p>		