STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675509	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parklane West Healthcare Center	2 Towers Park LN San Antonio, TX 78209

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observation, interview, and record review, the facility failed to ensure residents received necessary treatment and services, consistent with professional standards of practice to promote wound healing and to prevent new pressure ulcers from developing for 2 of 3 residents (Resident #1 and #2) reviewed for pressure injuries. 1. The facility nurses did not provide wound care to Resident #1 on 03/20/2025 and 03/24/2025. However, the physician order indicated Cleanse left glute, lateral malleolus, medial calf, and right plantar with wound cleanser, gently pat dry with gauze, apply skin prep to peri wound, apply medi-honey, cover with calcium alginate and secure with dry dressing daily - every day. 2. The facility nurses did not provide wound care to Resident #2 on 03/25/2025. However, the physician order indicated Cleanse third digit right toe with wound cleanser, gently pat dry with gauze, apply betadine and LOTA (leave open to air) daily - every day. This failure could place residents at risk of improper wound management, the development of new pressure injuries, deterioration in existing pressure injuries, infection, and pain. Findings included: 1. Record review of Resident #1's face sheet, dated 03/26/2025, revealed the resident was [AGE] years old, male, originally admitted to the facility on [DATE], and readmitted to the facility on [DATE] with the diagnosis of cellulitis of left lower limb (skin infection), abnormity of gait and mobility, cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it), type 2 diabetes mellitus (uncontrolled blood sugars), and edema (swelling caused by fluid). Record review of Resident #1's Medicare 5 days MDS assessment, dated 02/21/2025, revealed the resident's BIMS was 15 out of 15, indicated the resident's cognition was intact and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) to sit-to-stand, chair-to-bed, and toilet transfer. Record review of Resident #1's comprehensive care plan, dated 03/18/2025, revealed [Resident #1] has pressure ulcer left buttock-stage 4, left malleolus (ankle)-stage 3, right plantar (bottom of foot)-unstageable, and left medical calf related to vascular ulceration. For interventions - Administered medications as ordered. (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: 675509	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parklane West Healthcare Center	2 Towers Park LN San Antonio, TX 78209

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's physician orders, dated 03/13/2025, revealed the resident had the orders of cleanse left glute (buttock) with wound cleanser, gently pat dry with gauze, apply skin prep to peri wound, apply medi-honey, cover with calcium alginate and secure with dressing daily, cleanse left lateral malleolus (ankle) with wound cleanser, gently pat dry with gauze, apply skin prep to peri wound, apply medi-honey, cover with calcium alginate and secure with dressing daily, cleanse left medial calf (side of lower leg) with wound cleanser, gently pat dry with gauze, apply skin prep to peri wound, apply medi-honey, cover with calcium alginate and secure with dressing daily, and cleanse right plantar (bottom of foot) with wound cleanser, gently pat dry with gauze, apply skin prep to peri wound, apply medi-honey, cover with calcium alginate and secure with dressing wrap with kerlix and secure with tape daily. Record review of Resident #1's treatment administration record, from 03/01/2025 to 03/31/2025, revealed there were empty blanks (no nurses' initials) on 03/20/2025 and 03/24/2025 for wound care to Resident #1's left glute (buttock), lateral malleolus (ankle), medial calf (lower leg), and right plantar (bottom of foot) daily - once a day. Observation on 03/26/2025 at 9:53 a.m. revealed wound care nurse was providing wound care to Resident #1 as ordered. The resident had wounds to his left buttock, left lower leg, left ankle, and right bottom of foot. The all wounds were very clean, no signs and symptoms related to infection such as redness, hot, and swelling, and no discharge from all wounds were noted. Interview on 03/26/2025 at 9:55 a.m. with Resident #1 stated he did not have any pain and received wound care from nurses, but sometimes the facility nurses missed his wound care. Interview on 03/26/2025 at 10:00 a.m. with wound care nurse stated wound care nurse started working at the facility as wound care nurse on 03/25/2025, and before the nurse worked as a wound care nurse, the charge nurse provided wound care to Resident #1. Interview on 03/25/2025 at 1:40 p.m. with Resident #1's charge nurse RN-A stated she worked on 03/20/2025 and 03/24/2025 from 6 am to 2 pm and did not provide wound care to Resident #1 because she was very busy at those dates. The RN-A said she did not remember if she passed the information regarding needing Resident #1's wound care to evening shift (2 pm to 10 pm) and might forget telling it to the nurses of evening shift. That was why the resident did not receive wound care on 03/20/2025 and 03/24/2025. Further interview on the RN-A said she should have ensured the resident received wound care as ordered on 03/20/2025 and 03/24/2025 by providing wound care or telling the resident needed to have wound care to nurses of evening shift, so the evening nurses might provide wound care to Resident #1. Resident #1 might have wound infection if he did not receive proper wound care. Interview on 03/26/2025 at 10:52 a.m. with Resident #1's provider NP stated Resident #1 was under the NP's care, and the NP assessed the resident at least two times a week. The latest assessment the NP conducted was 03/25/2025. Further interview with the NP said Resident #1 did not have infection, and his blood sugars were controlled very well; therefore, only two days for missing wound care did not affect any negative outcomes to Resident #1. Interview on 03/26/2025 at 1:27 p.m. with DON stated facility nurses should have provided wound cares to Resident #1 as ordered, which was every day no matter what situation nurses had. Resident #1 did not have any negative effects, such as wound infection, but the resident might have wound infection if nurses did not provide wound care as ordered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675509	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Parklane West Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2 Towers Park LN San Antonio, TX 78209	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #2's face sheet, dated 03/26/2025, revealed the resident was [AGE] years old, male, and admitted to the facility on [DATE] with diagnosis of hyperkalemia (high level of potassium in the blood), type 2 diabetes mellitus (uncontrolled blood sugars), atrial flutter (heart's upper chambers beat too quickly), hyperlipidemia (high level of fat in the blood), and hypertension (high blood pressure). Record review of Resident #2's admission MDS revealed the resident's MDS was still in progress because he was admitted to the facility on [DATE]. Record review of Resident #2's admission BIMS assessment, dated 03/18/2025, revealed the resident's BIMS was 15 out of 15, indicated the resident's cognitive was intact. Record review of Resident #2's baseline care plan, dated 03/19/2025, revealed [Resident #2] admitted with skin impairment to lower extremities - right middle toe (3rd toe). For intervention - clean right third digit with wound cleanser, gently pat dry with gauze, apply betadine, and leave open to air daily - every day. Record review of Resident #2's physician order, dated 03/18/2025, revealed Wound care: Cleanse third digit right toe with wound cleanser, gently pat dry with gauze, apply betadine and leave open to air daily. Every day for diabetic ulcer. Record review of Resident #2's treatment administration record, from 03/01/2025 to 03/31/2025, revealed wound care nurse documented on 03/25/2025 as 7, which indicated the wound care nurse document to nursing progress note, and the progress note indicted the wound care nurse did not provide the wound care on 03/25/2025 because the nurse could not find the resident at the facility. Observation on 03/26/2025 at 9:27 a.m. revealed wound care nurse was providing wound care to Resident #2 as ordered. The resident had wound to third toe of his right foot with one cent size. No signs and symptoms of infection and no discharge was noted. Wound was very clean. Interview on 03/26/2025 at 9:37 a.m. with Resident #2 stated he did not have any pain, and facility nurses provided wound care every day, but only yesterday (03/25/2025) he did not receive wound care. Further interview with the resident denied any neglect. Interview on 03/26/2025 at 9:47 a.m. with wound care nurse said she tried to find Resident #2 to provide wound care, but the wound care nurse could not find the resident at the facility. The wound care nurse wrote Resident #2 needs to have wound care when he was available to 24-hour nursing shift report to make sure evening or night charge nurse would provide wound care to the resident, but due to lack of communication between the wound care nurse to the charge nurses, the nurses wound not provide the wound care to Resident #2 on 03/25/2025. To prevent wound infection, the nurses should have provided wound care to the resident every day as ordered. Interview on 03/26/2025 at 1:27 p.m. with DON stated she tried to call evening charge nurses or night charge nurses who worked on 03/25/2025 to find out what reason they did not provide the wound care to Resident #2, but nobody answered the phone calls. However, facility nurses should have provided wound cares to Resident #2 as ordered, which was every day and no matter what situation nurses had. Resident #2 did not have any negative effects, such as wound infection at this time, but the resident might have wound infection if nurses did not provide wound care as ordered. (continued on next page)

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Parklane West Healthcare Center	2 Towers Park LN San Antonio, TX 78209

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy, titled Skin and Wound Monitoring and Management, revised 12/2023, revealed A resident having pressure injury(s) receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on interviews and record reviews, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for one (Resident #1) out of three residents reviewed for documentation of wound care dressing changes. The facility failed to document wound care dressing changes on the Treatment Administration Record (TAR) for Resident #1 on 03/14/2025, 03/15/2025, 03/16/2025, 03/19/2025, 03/22/2025, and 03/23/2025. These failures placed residents at risk for missed treatments and care which could result in the wound deterioration, and development of infection. Findings included: Record review of Resident #1's face sheet, dated 03/26/2025, revealed the resident was [AGE] years old, male, originally admitted to the facility on [DATE], and readmitted to the facility on [DATE] with the diagnosis of cellulitis of left lower limb (skin infection), abnormity of gait and mobility, cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it), type 2 diabetes mellitus (uncontrolled blood sugars), and edema ([NAME] caused by fluid). Record review of Resident #1's Medicare 5 days MDS assessment, dated 02/21/2025, revealed the resident's BIMS was 15 out of 15, indicated the resident's cognitive was intact and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) to sit-to-stand, chair-to-bed, and toilet transfer. Record review of Resident #1's comprehensive care plan, dated 03/18/2025, revealed [Resident #1] has pressure ulcer left buttock-stage 4, left malleolus (ankle)-stage 3, right plantar (bottom of foot)-unstageable, and left medical calf related to vascular ulceration. For interventions - Administered medications as ordered. Record review of Resident #1's physician orders, dated 03/13/2025, revealed the resident had the orders of cleanse left glute (buttock) with wound cleanser, gently pat dry with gauze, apply skin prep to peri wound, apply medi-honey, cover with calcium alginate and secure with dressing daily, cleanse left lateral malleolus (ankle) with wound cleanser, gently pat dry with gauze, apply skin prep to peri wound, apply medi-honey, cover with calcium alginate and secure with dressing daily, cleanse left medial calf (side of lower leg) with wound cleanser, gently pat dry with gauze, apply skin prep to peri wound, apply medi-honey, cover with calcium alginate and secure with dressing daily, and cleanse right plantar (bottom of foot) with wound cleanser, gently pat dry with gauze, apply skin prep to peri wound, apply medi-honey, cover with calcium alginate and secure with dressing wrap with kerlix and secure with tape daily. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's treatment administration record, from 03/01/2025 to 03/31/2025, revealed there were empty blanks (no nurses' initials) on 03/14/2025, 03/15/2025, 03/16/2025, 03/19/2025, 03/22/2025, and 03/23/2025 for wound care to Resident #1's left glute (buttock), lateral malleolus (ankle), medial calf (lower leg), and right plantar (bottom of foot) daily - once a day. Interview on 03/26/2025 at 9:55 a.m. with Resident #1 stated he did not have any pain at this time and received wound cares from nurses. Interview on 03/25/2025 at 11:00 a.m. with Resident #1's charge nurse RN-A stated she provided wound care to Resident #1 on 03/14/2025 and 03/19/2025 as ordered, but she forgot documenting on Resident #1's treatment administration record because she was very busy at those dates. Further interview with the RN-A stated she should have documented on Resident #1's treatment administration record after providing wound care on 0314/2025 and 03/19/2025. It was RN-A's mistake, and the resident might have improper wound care due to lack of documentations. Interview on 03/25/2025 at 3:54 p.m. with LVN-B stated he provided wound cares to Resident #1 on 03/15/2025, 03/16/2025, 03/22/2025, and 03/23/2025 but did not document on Resident #1's treatment administration record because he forgot documenting on those dates. Further interview with LVN-B said he generally worked for weekend, and he provided all wound cares during weekend because wound care nurse did not work during weekend. Resident #1 allowed only LVN-B to provide the wound care even though LVN-B was not the resident's charging nurse, and LVN-B provided wound care. However, it made sometimes LVN-B to forget documenting. Interview on 03/26/2025 at 1:27 p.m. with DON stated RN-A and LVN-B should have documented on Resident #1's treatment administration record after they provided wound care to the resident. It was basic nursing responsibility, and if they did not document correctly, it might cause improper wound care to Resident #1 due to lack of communications. Record review of the facility policy, titled Daily Skilled Nursing documentation, effective date 10/01/2013, revealed All skilled services provided to the resident receiving skilled level of care, or any changed in resident/s medical or mental condition shall be documented in the resident's medical record.