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	07/17/2025

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. (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

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure resident medical records were kept in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete and accurately documented for 3 of 11 residents (Resident #1, Resident #2, and Resident #4) reviewed for clinical records. 1. The facility failed to obtain a physician's order to provide Resident #1 with indwelling catheter care and monitoring for 12 of 12 days (06/28/2025 to 07/09/2025) after admission and failed to ensure Resident #1's daily indwelling catheter care was documented in her medical record for 2 of 12 days (07/08/2025 and 07/09/2025). 2. The facility failed to obtain a physician's order to provide Resident #2 with indwelling catheter and monitoring for 2 of 3 days (06/22/2025 and 06/23/2025) after admission. 3. The facility failed to ensure Resident #4's weekly skin assessments were documented in his medical record for 2 of 15 weeks (the weeks of: 05/15/2025 and 05/22/2025). These failures could place residents at risk of not having accurate medical records and could create confusion in services provided or needed to be provided.The findings included: 1. Record review of Resident #1's admission Record, dated 07/16/2025, reflected Resident #1 was admitted on [DATE] and discharged on 07/10/2025. Resident #1 was noted to be [AGE] years old. Record review of Resident #1's Diagnosis Report, undated and accessed 07/14/2025, reflected Resident #1 was diagnosed with other sequelae of cerebral infarction (long-term complications or effects that can occur after a stroke), acute kidney failure (a sudden condition when the kidneys stop working or being able to filter waste products from the blood), and chronic kidney failure, stage 3 (a condition where the kidneys lose their ability to filter blood and remove wastes). Record review of Resident #1's admission MDS assessment, dated 06/30/2025, reflected it had been completed and signed by MDS Coordinator A on 07/12/2025. Resident #1's BIMS score of 12 indicated she was mildly cognitively impaired, and her bowel and bladder appliances noted she had an indwelling catheter (a tube inserted into the body). Record review of Resident #1's hospital transfer documents, dated 06/25/2025, reflected Resident #1 had a foley (an indwelling catheter to drain urine from the bladder) approved for comfort. Record review of Resident #1's LN- Initial admission Record, signed and dated 06/27/2025 at 06:45 p.m. by LPN D, reflected Resident #1 had a urinary indwelling catheter in place. Record review of Resident #1's Order Recap Report, order dates 06/27/2025 to 07/31/2025, did not reflect physician orders for an indwelling catheter or the care and monitoring of an indwelling catheter. Record review of Resident #1's MAR, dated 06/01/2025- 06/30/2025, did not reflect physician orders for an indwelling catheter or the care and monitoring of an indwelling catheter. Record review of Resident #1's MAR, dated 07/01/2025- 07/31/2025, did not reflect physician orders for an indwelling catheter or the care and monitoring of an indwelling catheter. Record review of Resident #1's Nursing Progress Note, by LPN D, effective 06/27/2025 at 05:55 p.m., reflected .She has an indwelling foley catheter. Record review of Resident #1's Daily Skilled Note Progress Note, by LPN E, effective 06/28/2025 at 10:39 a.m., reflected Urine is [sic] pt has indwelling foley cath, urine is yellow and clear, no foul odor noted, no c/o dysuria [painful urination] [sic] Active SX: retention / distension of bladder. GU appliance used is an indwelling catheter. Other observations and interventions include Indwelling [sic] foley cath is drainingwell [sic] via gravity, no sediment noted, pt is tolerating well, no c/o pain or discomfort. Record review of Resident #1's Daily Skilled Note Progress Note, by LPN E, effective 06/29/2025 at 06:00 p.m., reflected Urine is [sic] pt has indwelling foley cath, urine is yellow and clear, no foul odor noted, no c/o dysuria [sic] No active Genitourinary/Renal symptoms observed. Record review of Resident #1's Daily Skilled Note Progress Note, by LPN D, effective 06/30/2025 at 11:31 p.m., reflected Urine is [sic] pt has indwelling foley cath, urine is yellow and clear, no foul odor noted, no c/o dysuria [sic] Other active symptoms or treatments are described below. GU appliance used is an indwelling catheter. Other observations and interventions include Resident [sic] has wounds and rash to perianal [area surrounding the anus] area- foley is to provide relief and promote skin integrity. Resident response to treatment is indweling [sic] foley catheter. Record review of Resident #1's Daily Skilled Note Progress Note, by LPN D, effective 07/01/2025 at 07:00 p.m., reflected Urine is [sic] pt has indwelling foley cath, urine is yellow and clear, no foul odor noted, no c/o dysuria [sic] No active Genitourinary/Renal symptoms observed. GU appliance used is an indwelling catheter. Other observations and interventions include Resident [sic] has wounds and rash to perianal area- foley is to provide relief and promote skin integrity. Resident response to treatment is indweling [sic] foley catheter. Record review of Resident #1's

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. (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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity for 2 of 4 (Residents #1 and #2) reviewed for assessments. 1. The MDS Coordinator failed to complete Resident #1's admission comprehensive assessment within 14 days after admission. MDS Coordinator A verified as complete on 07/12/2025. Resident #1 was admitted on [DATE]. 2. The MDS Coordinator failed to complete Resident #2's admission comprehensive assessment within 14 days after admission. MDS Coordinator A verified as complete on 07/13/2025. Resident #2 was admitted on [DATE]. This failure could affect newly admitted residents and result in residents not receiving the care and services as needed.The findings included: 1. Record review of Resident #1's admission Record, dated 07/16/2025, reflected Resident #1 was admitted on [DATE] and discharged on 07/10/2025. Resident #1 was noted to be [AGE] years old. Record review of Resident #1's Diagnosis Report, undated and accessed 07/14/2025, reflected Resident #1 was diagnosed with other sequelae of cerebral infarction (long-term complications or effects that can occur after a stroke), acute kidney failure (a sudden condition when the kidneys stop working or being able to filter waste products from the blood), and chronic kidney failure, stage 3 (a condition where the kidneys lose their ability to filter blood and remove wastes). Record review of Resident #1's admission MDS assessment, dated 06/30/2025, reflected Resident #1 was admitted on [DATE] and had a BIMS score of 12 indicating she was mildly cognitively impaired. The admission MDS assessment was completed and signed by MDS Coordinator A on 07/12/2025; 15 days after Resident #1's admission. Interview with Resident #1, at a local hospital, on 07/13/2025 at 02:37 p.m., revealed Resident #1 admitted , on 07/10/2025, to a local hospital. Resident #1 stated she did not feel she had consistent care at the nursing facility; however, Resident #1 was noted as a poor historian and was mixing her complaints between the recent nursing facility administration and a prior assisted living administration. Resident #1 ended conversation by stating she only had complaints regarding the assisted living. 2. Record review of Resident #2's admission Record, dated 07/16/2025, reflected Resident #2 was admitted on [DATE]. Resident #2 was noted to be [AGE] years old. Record review of Resident #2's Diagnosis Report, undated and accessed 07/16/2025, reflected Resident #2 was diagnosed with displaced intertrochanteric fracture of right femur (a break in the hip bone), thrombocytopenia (a low number of platelets, which are blood cells that cause clotting, in the blood), and dementia (a general term for impaired ability to remember, think, or make decisions). Record review of Resident #2's EMR (electronic medical record) on 07/16/2025, reflected Resident #2 had four MDS Assessments, an Entry MDS, dated [DATE], and noted as Accepted, an admission - None PPS MDS, dated [DATE], and noted as Accepted, a Medicare- 5 Day MDS, dated [DATE], and noted as Completed, and a Discharge Return NotAnticipated [sic] MDS, dated [DATE], and noted as In Progress. Record review of Resident #2's admission MDS assessment, dated 06/23/2025, reflected Resident #2 was admitted on [DATE] and had a BIMS score of 02 indicating she was moderately cognitively impaired. The admission MDS assessment was completed and signed by MDS Coordinator A on 07/13/2025; 23 days after Resident #2's admission. Observation and attempted interview with Resident #2 on 07/17/2025 at 09:40 a.m. Resident #2 observed to lying in bed, watching her television. Resident #2 observed to be alert, but her speech was garbled and her response to questions was inconsistent to interview prompt. During an interview on 07/16/2025 at 09:26 a.m., MDS Coordinator A stated she worked on a PRN (as needed) basis. She revealed she would review the in-progress list and just complete the MDS Assessments that needed to be done. She stated a late MDS Assessment would impact a resident depending on the specific sections of the MDS Assessment that were not completed. She did not clarify how an assessment signed late could impact a resident. During an interview on 07/16/2025 at 09:41 a.m., MDS Coordinator B stated the assessments were scheduled based on the RAI (Resident Assessment Instrument). MDS Coordinator B stated the facility had herself and another MDS Coordinator, MDS Coordinator C, completing the assessments, but MDS Coordinator C was new and still in training. She stated MDS Coordinator A was working PRN and MDS Coordinator A would review and complete the MDS Assessments that were in-progress. MDS Coordinator B stated Resident #1's admission MDS was probably signed late because the MDS Coordinators were behind and still attempting to get caught up. MDS Coordinator B was not asked about Resident #'2's admission MDS. MDS Coordinator B stated a late MDS Assessment could impact a resident because it could delay

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person- centered care of the residents that meets professional standards of quality of care within 48 hours of a resident's admission for 1 of 5 (Resident #1) reviewed for baseline care plans. The facility failed to include Resident #1's catheter care and monitoring in her initial baseline care plan dated 06/28/2025, when Resident #1 was admitted on [DATE]. This deficient practice could place residents at risk of not having their individual care needs met in a timely manner or diminished quality of life, infection, and hospitalization.The findings included: Record review of Resident #1's admission Record, dated 07/16/2025, reflected Resident #1 was admitted on [DATE] and discharged on 07/10/2025. Resident #1 was noted to be [AGE] years old. Record review of Resident #1's Diagnosis Report, undated and accessed 07/14/2025, reflected Resident #1 was diagnosed with other sequelae of cerebral infarction (long-term complications or effects that can occur after a stroke), acute kidney failure (a sudden condition when the kidneys stop working or being able to filter waste products from the blood), and chronic kidney failure, stage 3 (a condition where the kidneys lose their ability to filter blood and remove wastes). Record review of Resident #1's hospital transfer documents, dated 06/25/2025, reflected Resident #1 had completed a 5-day course of antibiotics for a urinary tract infection but no growth was found on the culture. She was noted to have genitourinary skin (skin around the genital and urinary organs) breakdown with a foley (an indwelling catheter to drain urine from the bladder) approved for comfort. Record review of Resident #1's LN- Initial admission Record, signed and dated 06/27/2025 at 06:45 p.m. by LPN D, reflected Resident #1 had a urinary indwelling catheter in place. Record review of Resident #1's admission MDS assessment, dated 06/30/2025, reflected it had been completed and signed by MDS Coordinator A on 07/12/2025. Resident #1's BIMS score of 12 indicated she was mildly cognitively impaired, and her bowel and bladder appliances noted she had an indwelling catheter (a tube inserted into the body). Record review of Resident #1's Initial Care Plan., signed and dated 06/28/2025 by the DON, did not reflect a focus or intervention regarding incontinent care or indwelling catheter care. Record review of Resident #1's IDT- Care Plan Review., signed and dated 07/03/2025, did not reflect person-centered comprehensive care planning on Bowel and Bladder Evaluation or Care Plan elements to include indwelling catheter care under additional comments, special treatments, procedures and devices, or additional nursing plan of care. Record review of Resident #1's Care Plan, accessed 07/14/2025, did not reflect a focus or intervention regarding incontinent care or indwelling catheter care. Record review of Resident #1's Nursing Progress Note, by LPN D, effective 06/27/2025 at 05:55 p.m., reflected .She has an indwelling foley catheter. Record review of Resident #1's Daily Skilled Note Progress Note, by LPN E, effective 06/28/2025 at 10:39 a.m., reflected Urine is [sic] pt has indwelling foley cath, urine is yellow and clear, no foul odor noted, no c/o dysuria [painful urination] [sic] Active SX: retention / distension of bladder. GU appliance used is an indwelling catheter. Other observations and interventions include Indwelling [sic] foley cath is drainingwell [sic] via gravity, no sediment noted, pt is tolerating well, no c/o pain or discomfort. Record review of Resident #1's Daily Skilled Note Progress Note, by LPN E, effective 06/29/2025 at 06:00 p.m., reflected Urine is [sic] pt has indwelling foley cath, urine is yellow and clear, no foul odor noted, no c/o dysuria [sic] No active Genitourinary/Renal symptoms observed. Record review of Resident #1's History and Physical Note Progress Note, by NP F, effective 06/30/2025 at 04:42 p.m., reflected While in hospital noted with UTI [urinary tract infection, an infection in any part of the urinary system] treated with Rocephin [antibiotic]. Has been experiencing diarrhea, n/v with no clear reason. foley cath was placed in hospital for skin integrity. Record review of Resident #1's Daily Skilled Note Progress Note, by LPN D, effective 06/30/2025 at 11:31 p.m., reflected Urine is [sic] pt has indwelling foley cath, urine is yellow and clear, no foul odor noted, no c/o dysuria [sic] Other active symptoms or treatments are described below. GU appliance used is an indwelling catheter. Other observations and interventions include Resident [sic] has wounds and rash to perianal [area surrounding the anus] area- foley is to provide relief and promote skin integrity. Resident response to treatment is indweling [sic] foley catheter. Record review of Resident #1's Daily Skilled Note Progress Note, by LPN D, effective 07/01/2025 at 07:00 p.m., reflected Urine is [sic] pt has indwelling foley cath, urine is yellow and clear, no foul odor noted, no c/o dysuria [sic] No active Genitourinary/Renal symptoms observed. GU appliance used is an indwelling catheter. Other observations and interventions include Resident [sic] has wounds and rash to perianal area-

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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. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident who had an indwelling catheter received appropriate treatment and services to prevent urinary tract infections for 1 of 2 (Resident #3) reviewed for indwelling catheter care. 1. The facility failed to ensure CNA S cleaned Resident #3's indwelling catheter properly during incontinent care. 2. The facility failed to ensure Resident #3's indwelling catheter was secured appropriately and per physician's order. These failure could place residents with indwelling catheters at risk for pain, infection, injury, and hospitalization. The findings included: 1. Record review of Resident #3's admission Record, dated 07/16/2025, reflected Resident #3 was admitted on [DATE]. Resident #3 was noted to be [AGE] years old. Record review of Resident #3's Diagnosis Report, undated and accessed 07/16/2025, reflected Resident #3 was diagnosed with displacement of indwelling urethral catheter (also known as a foley catheter, a tube inserted in the urethra to drain urine), urinary tract infection, and type 2 diabetes mellitus (a condition that develops with the way the body regulates and uses sugar as fuel). Record review of Resident #3's admission MDS assessment, dated 04/29/2025, reflected Resident #3's had a BIMS score of 14, indicating he was cognitively intact. He was noted to have an indwelling catheter and always incontinent of bowel. Record review of Resident #3's Order Summary Report, dated active orders as of 07/16/2025, reflected the orders: - CHANGE LEG STRAP EVERY WEEK and AS NEEDED as needed [sic], order status noted as Active, order date and start date of 04/28/2025. - CHANGE LEG STRAP EVERY WEEK and AS NEEDED one time a day every 7 day(s), order status noted as Active, order date of 04/28/2025 and start date of 04/29/2025.- SECURE CATHETER WITH A LEG STRAP/LEG BAND OR ANCHOR TO MINIMIZE CATHETER RELATED INJURY AND ACCIDENTAL REMOVAL OR OBSTRUCTION OF URINE OUTFLOW, CHECK PLACEMENT as needed, noted as Active, order date and start date of 04/25/2025.- SECURE CATHETER WITH A LEG STRAP/LEG BAND OR ANCHOR TO MINIMIZE CATHETER RELATED INJURY AND ACCIDENTAL REMOVAL OR OBSTRUCTION OF URINE OUTFLOW, CHECK PLACEMENT every shift, noted as Active, order date and start date of 04/25/2025. During an interview on 07/15/2025 at 01:02 p.m., the DON revealed CNAs were expected to empty the resident foley catheters and record the output. She revealed the facility completed skills checkoffs with the CNAs and they were to notify a nurse if they observed a urine color change, such as blood in the urine. During an observation on 07/16/2025 at 10:52 a.m., CNA S was providing incontinent and foley catheter care to Resident #3. No leg strap was noted to be present, securing Resident #3's catheter tubing in place. CNA S was observed to clean Resident #3's perineum (area between the genitals and anus), thigh folds, shaft and head of the penis, and around the catheter insertion site, but did not clean the catheter. During an interview on 07/16/2025 at 11:58 a.m., CNA S stated she needed to notify the nurse Resident #3 did not have a leg strap on his catheter. She stated residents with catheters should have a leg strap on at all times. She stated Resident #3 had just returned from a shower and sometimes they come loose in the shower, however; he did not have one on this morning, 07/16/2025, before his shower. CNA S stated she did not clean the catheter when providing perineal care. She stated she knew she was supposed to clean the catheter by holding it and wiping from the tip away from the body. She stated she was distracted because there was a lot going on, her gown kept falling off, and she was nervous. During an interview on 07/17/2025 at 09:45 a.m., Resident #3 stated he did not have any concerns about his foley catheter care. He stated the staff check and clean his foley catheter well. During an interview on 07/17/2025 at 09:46 a.m., CNA S stated she messed up. She revealed it was part of her training to always clean the tubing and if the resident complained of pain, clean it and then let the nurse know. She stated there were a lot of distractions with the roommate continuously asking what was going on, her phone alarm going off for her scheduled break, and another CNA had asked for assistance. She stated her nerves just got the best of her. During an interview on 07/17/2025 at 03:34 p.m., the DON stated CNAs were expected to perform foley catheter care, including monitoring. She revealed the CNAs were to empty the foley catheters, but the nurses were to monitor for signs and/or symptoms of urinary tract infections. Record review of facility policy, Indwelling Urinary Catheter Care, dated revised/reviewed April 2025, revealed under Procedure, 9.clean the catheter in a downward motion (front to back) beginning at the urinary meatus (insertion point) and at least 4 inches down (from resident toward the collection bag).12. May secure the tubing with a securement device, as needed (PRN) to prevent migration, friction, or tension of the catheter.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure resident medical records were kept in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete and accurately documented for 1 of 11 residents (Resident #4) reviewed for clinical records. The facility failed to ensure Resident #4's weekly skin assessments were documented in his medical record for 2 of 15 weeks (the weeks of: 05/15/2025 and 05/22/2025). These failures could place residents at risk of not having accurate medical records and could create confusion in services provided or needed to be provided.The findings included: Record review of Resident #4's admission Record, dated 07/14/2025, reflected a [AGE] year-old male. He was originally admitted on [DATE] and re-admitted on [DATE]. Record review of Resident #4's Diagnosis Report, undated and accessed on 07/15/2025, reflected Resident #4 was diagnosed with type 2 diabetes mellitus, muscle weakness, and dysphagia (difficulty swallowing). Record review of Resident #4's Annual MDS Assessment, dated 04/30/2025, reflected Resident #4 had a BIMS score of 15 indicating he was cognitively intact. He was noted to be at risk of developing pressure ulcers/injuries but did not have any pressure ulcers/injuries, venous or arterial ulcers, or other ulcers, wounds, or skin problems. Record review of Resident #4's Care Plan, undated and accessed 07/15/2025, reflected a focus Has potential to skin integrity r/t Fragile skin, date initiated and revised 07/17/2025 with interventions to include Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration etc. to MD. Record review of Resident #4's EMR Assessment tab, undated and accessed on 07/15/2025, did not reflect a LN- Skin Evaluation - PRN / Weekly or LN- Skin Ulcer Non-Pressure Weekly, assessment dated for the week of 05/15/2025 or for the week of 05/22/2025. Record review of Resident #4's Progress Notes, dated 05/01/2025 to 05/28/2025 did not reveal notes regarding Resident #4's skin status effective on the weeks of 05/15/2025 or 05/22/2025. During an interview on 07/15/2028 at 10:10 a.m., Resident #4 revealed he had not experienced any recent skin issues, and the facility staff had just recently completed his skin assessment without finding concerns. She stated he did not know how often his skin was assessment but believed it was more than once a month. During an interview on 07/14/2025 at 02:46 p.m., Treatment Nurse U stated she had been working as the Treatment Nurse for around 2 months. She stated the floor nurses and her were responsible for completing the weekly skin assessments. She stated she believed the floor nurses had a binder to notify them of the schedule for when the skin assessments were due. She stated she would often complete the weekly skin assessments for residents with wound care, such as those with surgical sites or pressure ulcers. During an interview on 07/15/2025 at 01:02 p.m., the DON stated the resident's skin assessments were to be done upon admission and then upon schedule weekly. She stated the treatment nurse would schedule the weekly skin assessments, and they were to document under the LN- Skin Assessments assessment. The DON stated, if an assessment was not listed under the assessments, the it might indicate there were no skin issues, the resident was out on pass, not available, or refused the assessment and there should be a progress note. The DON stated, if an assessment was not documented it might be due to a computer glitch, but she would have to investigate why the assessment was missed. She stated, if not documented then it (the assessment) didn't happen. She stated a missed skin assessment would result in the staff not having a full picture of the resident's status at that time. During an interview on 07/15/2025 at 02:43 p.m., the DON stated she still had not located Resident #4's skin assessments for the weeks of 05/15/2025 or 05/22/2025. Record review of the facility's policy, Skin and Wound Monitoring and Management, dated revised December 2023, reflected under Procedure, a. Resident Assessment.g. Ongoing Skin and Wound Assessments: A licensed nurse will assess/evaluate a resident's skin at least weekly.4. Documentation.b. Weekly Skin Check - Licensed nurse should document skin evaluations in accordance with this policy and document on the appropriate skin assessment/evaluation weekly/PRN form.6. Monitoring. d. Weekly skin check conducted by a licensed nurse - All resident will have a head to toe skin check performed at least weekly by a licensed nurse. - The licensed nurse should document the findings.

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	07/17/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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	07/17/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to establish and 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 diseases and infections for 2 of 2 residents (Resident #3 and Resident #5) and 2 of 2 staff (CNA S and CNA T) reviewed for infection control. 1. The facility failed to ensure CNA S properly secured her personal protective equipment during indwelling catheter and incontinent care for Resident #3 on 07/16/2025. 2. The facility failed to ensure CNA T wore appropriate PPE for EBP during indwelling catheter and incontinent care for Resident #5 on 07/16/2025. These failures could place residents at risk of exposure to infectious diseases due to improper infection control practices. Findings included: 1. Record review of Resident #3's admission Record, dated 07/16/2025, reflected Resident #3 was admitted on [DATE]. Resident #3 was noted to be [AGE] years old. Record review of Resident #3's Diagnosis Report, undated and accessed 07/16/2025, reflected Resident #3 was diagnosed with displacement of indwelling urethral catheter (also known as a foley catheter, a tube inserted in the urethra to drain urine), urinary tract infection, and type 2 diabetes mellitus (a condition that develops with the way the body regulates and uses sugar as fuel). Record review of Resident #3's admission MDS assessment, dated 04/29/2025, reflected Resident #3's had a BIMS score of 14, indicating he was cognitively intact. He was noted to have an indwelling catheter and always incontinent of bowel. Record review of Resident #3's Order Summary Report, dated active orders as of 07/16/2025, reflected the order, ENHANCED BARRIER PRECAUTIONS: PPE required for high resident contact care activities. Indication: Indwelling medical device every shift, order status noted as Active, order date and start date of 04/26/2025. During an observation on 07/16/2025 at 10:52 a.m., revealed CNA S was providing incontinent and foley catheter care to Resident #3. CNA S was observed to put on a personal protective gown but did not secure the back ties resulting in the gown falling forward off her shoulders several times, requiring adjustment. During an interview on 07/16/2025 at 11:58 a.m., CNA S stated she was distracted while performing incontinent and foley catheter care for Resident #3 because there was a lot going on, her gown kept falling off, and she was nervous. During an interview on 07/17/2025 at 09:45 a.m., Resident #3 stated he did not have any concerns about his foley catheter care. He stated the staff check and clean his foley catheter well. During an interview on 07/17/2025 at 09:46 a.m., CNA S stated for the gown, she put it on but didn't fasten it. She stated she usually would knot the top fastening of the gown prior to putting it over her head but didn't this time. She stated she was nervous. She stated the facility provided her training on PPE and she took an online PPE (personal protective equipment) training about donning and doffing (putting on and taking off) PPE last month. 2. Record review of Resident #5's admission Record, dated 07/16/2025, reflected Resident #5 was initially admitted on [DATE] and readmitted on [DATE]. Resident #5 was noted to be [AGE] years old. Record review of Resident #5's Diagnosis Report, undated and accessed 07/16/2025, reflected Resident #5 was diagnosed with fluid overload, chronic obstructive pulmonary disease (a type of progressive lung disease), and type 2 diabetes mellitus. Record review of Resident #5's Quarterly MDS assessment, dated 06/04/2025, reflected Resident #5 had a BIMS score of 13, indicating he was cognitively intact. He was noted to have an indwelling catheter and always incontinent of bowel and bladder. Record review of Resident #5's Order Summary Report, dated active orders as of 07/16/2025, reflected the order, ENHANCED BARRIER PRECAUTIONS: PPE required for high resident contact care activities. Indication: Catheter/ wounds every shift, order status noted as Active, order date and start date of 04/15/2025. During an observation on 07/16/2025 at 11:18 a.m., revealed CNA T was providing incontinent and foley catheter care to Resident #5. CNA T was observed to not put on a personal protective gown during care. An EBP (enhanced barrier precaution) sign was noted on Resident #5's door prior to entering room. During an interview on 07/16/2025 at 11:29 a.m., CNA T stated she did not wear a protective gown for enhance barrier precautions. She stated she should have read the sign but missed it. She stated she normally looks for the boxes of PPE outside of the resident room to tell her the resident was on precautions, but did not see one for Resident #5's room. CNA T stated she was new to the facility, did not know anything about EBP, and had never been told. During an interview on 07/17/2025 at 09:50 a.m., Resident #5 stated he did not have any concerns about his foley catheter care. He stated the staff provided good care with emptying and cleaning his catheter. During an interview on 07/17/2025 at 02:58 p.m., CNA T stated the facility had provided her