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	11/26/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed make sure that drugs were stored properly and only authorized persons had access to one of two carts reviewed for drug storage and labeling on Hall A 3rd floor.The facility failed to ensure the 3rd floor Hall A medication cart was locked and medications were secured and not accessible to other staff, residents, or visitors.This failure could place residents at risk of having unauthorized access to medications, decreased effectiveness of medication, or missing medications.Findings Included:Observation of 3rd floor Hall A medication cart on 11/25/2025 at 3:29 PM revealed it was unattended and locked with each drawer opening when pulled. LVN A was seated at the nurse's station and was ask to review the cart. The medication cart was up against the wall in the 3rd floor Hall A corridor. The locking mechanism was pushed in signifying a locked position and was not secured with each drawer opening when pulled. The cart contained prescribed medication for residents and over the counter medications. LVN A walked to the cart from the nurse's station and pulled on each drawer which opened.Interview and observation on 11/25/2025 at 3:30 PM revealed LVN A had worked at the facility since May of 2025. She revealed she did not understand why the cart was locked and the drawers could be opened. LVN A took the action of unlocking the exterior cart lock, opening and closing each drawer one at a time to ensure that each one was fully closed, and re-locking the cart. She said she was responsible for ensuring the medication cart was locked. She said if a medication cart was left unlocked and unattended then medications could go missing by a resident, family member, and staff. She said this could lead to an overdose. She revealed that one drawer could have been slightly ajar causing the lock to not engage and secure the medications on the cart.An interview with the ADON A on 11/26/2025 at 03:25 PM revealed she had worked at the facility since June of 2025. She said that a resident with dementia could take a medication that they should not take if the medication cart was left unattended and unlocked. She revealed that someone accessing the cart could have an allergy from using a medication that was not prescribed for them. She revealed that the unattended and unlocked cart could lead to drug diversion.An interview with the DON on 11/26/2025 at 3:45 PM revealed that the concern with an unsecured cart that is left unattended was that residents could take medication that they are not supposed to take.Record review of Medication Administration: Medication Carts and Supplies for Administering Medication Policy revised 05/2007 revealed:Policy: It is the policy of the facility to store all drugs and biologicals in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff lawfully authorized to administer medications. Procedure: Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (e.g. medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675509	A. Building B. Wing	11/26/2025

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 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. (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	11/26/2025

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to maintain medical records that were complete and accurately documented for 3 of 3 residents (Resident #1, Resident #2, Resident #3) reviewed during the complaint investigation. The facility failed to ensure that Resident #1's treatment administration record noted treatments on 9.6.2025, 9.20.2025, 10.2.2025, 10.25.2025 as required by the orders noted on the electronic medical record. The facility failed to ensure that Resident #2's treatment administration record noted treatments on 9.2.2025, 11.5.2025 as required by the orders noted on the electronic medical record. The facility failed to ensure that Resident #3's treatment administration record noted treatments on 10.3.2025, 10.10.2025, 10.15.2025, 10.26.2025, 11.2.2025 as required by the orders noted on the electronic medical record. This failure could place residents at risk of not receiving necessary care and services daily as ordered by the physician to promote proper healing of active wounds.Findings include: During an observation and interview on 11.25.2025 at 4:20 PM, Resident #1 was observed seated in his wheelchair with his left foot bandaged at the ankle. He stated that he was receiving treatment for two wounds. The other wound was on his left buttock.Record review of Resident #1's admission record, dated 11.25.2025, reflected a [AGE] year-old male who was readmitted to the facility on 2.17.2025 with diagnoses of type 2 diabetes (a chronic condition that affects the way the body metabolizes sugar leading to high blood sugar levels) with foot ulcer (open wound), unspecified cirrhosis (inflammation and scaring) of the liver, other peripheral vascular (affects the blood vessels) diseases, stage 4 pressure ulcer (open wound) of left buttock, stage 4 pressure ulcer (open wound) of left ankle, non-pressure chronic ulcer(open wound) of unspecified part of left lower leg limited to breakdown of skin, and cellulitis (bacterial skin infection) of left lower limb.Record review of Resident #1's MDS assessment completed on 9.1.2025 revealed a BIMS score of 15 which indicated no significant cognitive impairment. Resident #1 was coded as receiving skin and ulcer/injury treatments for stage 4 pressure ulcers. Resident #1 was coded as using a motorized wheelchair to ambulate. Record review of Resident #1's Comprehensive Care Plan, dated 4.14.2025, reflected venous ulcer to the left ankle related to diabetes, vascular insufficiency, poor glycemic control, non-compliance with diet, and edema requiring wound monitoring and treatment. Record review of Resident #1's TAR record for September of 2025 and October of 2025 revealed that wound care for the left ankle was to be performed once a day with an order start date of 8.14.2025. Wound care for the lower left buttocks was to be performed once a day with an order start date of 8.27.2025. Record review of Resident #1's TAR record for the month of September and October revealed staff had failed to mark completion of wound care treatment on 9.6.2025, 9.20.2025, 10.2.2025, and 10.25.2025 as required by the orders noted on the electronic medical record.Record review of Resident #2 admission Record revealed that the resident was discharged from the facility on 11.18.2025 to an acute care hospital.Record review of Resident #2's admission record, dated 11.25.2025, reflected an [AGE] year-old female who was readmitted to the facility on 11.02.2025 with diagnoses of unstageable pressure ulcer (open wound) of the sacral (triangular bone at the base of the spine) region, chronic obstructive pulmonary (lung) disease, morbid obesity (over weight), diabetes mellitus 2 (a chronic condition that affects the way the body metabolizes sugar leading to high blood sugar levels), unspecified severe calorie malnutrition, and chronic respiratory failure with hypoxia (low levels of oxygen in body tissue).Record review of Resident #2's MDS assessment completed on 11.13.2025 revealed a BIMS score of 3 which indicated severe cognitive impairment. Resident #1 was coded as dependent where a helper does all the effort for mobility in bed and transfers out of bed and self-care needs. The resident was always incontinent. The resident was coded as having an unstageable pressure ulcer requiring ulcer/injury care. Record review of Resident #2's Comprehensive Care Plan, dated 9.1.2025, reflected the resident has a stage IV pressure ulcer requiring wound vac, wound treatments, wound monitoring, turning, repositioning, enhanced barrier precautions, and a low air loss mattress. Record review of Resident #2's TAR record for the month of September 2025 and November 2025 revealed that wound care for the sacrum was to be performed once a day with an order start date of 9.1.2025. Record review of Resident #2's TAR record for the month of September and October revealed staff had failed to mark completion of wound care treatment on 9.2.202 and 11.5.2025 as required by the orders noted on the electronic medical record. During an observation and interview on 11.25.2025 at 5:00 PM, Resident #3 was observed lying in bed with a boot on his left foot. He stated that he had one small wound. He said he was supposed to receive wound care every day for his heel