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	12/07/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0583 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 ensure personal privacy for 1 of 2 residents (Resident #11) reviewed for privacy, in that: Resident #11 was observed in the hallway on 12/07/2025 with his foley bag attached to right calf without a privacy cover, exposing his foley bag contents to anyone in the hallway. This deficient practice could affect residents by resulting in loss of dignity and low self-esteem. The findings were: Record review of Resident #11's undated face sheet revealed Resident #11 was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (a chemical imbalance in the blood that causes problems in the brain), acute kidney failure (a condition where the kidneys stop working), Alzheimer's disease (a progressive disease that affects memory and other important mental functions) and legal blindness (a definition used to assess the severity of visual impairment). Record review of Resident #11's undated comprehensive care plan revealed a care plan, date initiated 09/30/2025, has indwelling catheter and an intervention that revealed, position catheter bag and tubing below the level of the bladder and away from entrance room door. Record review of Resident #11's annual MDS assessment, dated 09/30/2025, revealed a BIMS score of 4, indicating severe cognitive impairment. Section B - Hearing, Speech and Vision revealed Resident #11 had severely impaired vision. Section GG - Functional Abilities revealed Resident #11 required partial assistance with transfers and ambulation. Record review of Resident #11's December 2025 MAR revealed an order, position privacy bag and tubing below the level of the bladder every shift, order date 09/29/2025. The MAR was initialed by LVN F on 12/07/2025 with a U. The chart code on the MAR revealed, U=Unknown. During an observation, 12/07/2025 at 1:12 p.m., Resident #11 was observed walking in the hallway with CNA A leading Resident #11 by the hands to an armchair and assisted Resident #11 to sit in the chair. Resident #11 was observed to be wearing knee length shorts. Resident #11 had a foley catheter bag attached by a leg strap at the top of Resident #11's right calf. The foley catheter bag did not have a privacy cover and the bag was observed to be over half full of yellow urine. During an interview with CNA A, 12/07/2025 at 1:14 p.m., CNA A stated Resident #11 had a foley catheter bag and said she had not observed a privacy cover for Resident #11 foley bag. CNA A stated the bag was attached to his upper calf when she came on shift at 6 a.m. and stated she did not think she had access to foley catheter bags. CNA A stated it was important for a resident to have a foley privacy bag, because it is privacy for the residents. CNA A stated she was not sure who was responsible for ensuring privacy bags were in place and stated she received education about ensuring privacy bags were in place when she was in CNA school. During an interview with Resident #11, 12/07/2025 at 1:18 p.m., Resident #11 stated the staff assist with his foley catheter bag and stated he was blind and did not know if he had a privacy cover on the bag. Resident #11 stated he did not care if he had a privacy cover or not and it did not bother him to not have a privacy cover. During an interview with the Operations Manager, 12/07/2025 at 3:08 p.m., The Operations Manager said a resident with a foley catheter bag should have had a privacy cover on the foley bag and said the nurse and the aides were responsible for ensuring the placement of privacy covers. The Operations Manager stated she was not sure if staff had received training on privacy covers and stated it was important for foley catheter bags to have privacy covers, for the resident's dignity. During an interview with LVN F, 12/07/2025 at 3:22 p.m., LVN F said he was assigned to Resident #11 and said residents with foley catheter bags should have had privacy covers on their bags. LVN F stated the nurse managers were responsible for ensuring privacy bags were in place and stated he only worked on the weekends and the nurse managers, should be more diligent on that. LVN F said he had access to foley privacy bags and said the bags were located in the supply room. LVN F stated he had received training on keeping privacy bags on foley catheter bags and stated he did not place a privacy bag on Resident #11's foley catheter bag on his shift on 12/07/2025. LVN F stated he observed Resident #11 in the hallway without a privacy cover and stated it was important for residents to have privacy covers, so it gives them privacy for their bag and protect their privacy and to give them respect and dignity. During an interview with the DON, 12/07/2025 at 3:30 p.m., the DON stated residents with foley catheter bags should have had a privacy cover over the bag and stated the charge nurses were responsible for ensuring a resident had a privacy cover. The DON stated staff had received training on privacy covers and stated privacy covers were available to staff in the supply room on each floor. The DON stated it was important to keep privacy bags on a resident's foley catheter bag, for patient privacy. Record review of a facility policy