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 03/05/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 2 of 3 residents (Residents #1 and #2) reviewed for care plans: 1.The facility failed to ensure Resident #1 comprehensive care plan included a plan with interventions to address her bathing and showering requirements. 2.The facility failed to ensure Resident #2's comprehensive care plan was developed to include interventions to address his ADL needs and requirements. These failures could place residents at risk of receiving improper care and services. The findings included: 1.Record review of Resident #1's face sheet, dated 2/19/2026, revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included: sequelae of cerebral infarction (stroke), vascular dementia without behavioral disturbance (a common form of dementia caused by an impaired supply of blood to the brain, such as may be caused by a series of small strokes), and need for assistance with personal care. Record review of Resident #1's quarterly MDS assessment, dated 11/21/2026, revealed a BIMS score of 00 which indicated the resident's cognition could not be scored and the resident could not be understood. Her functional abilities were maximal assistance with bathing and total dependance on staff for personal hygiene/toileting. Record review of Resident #1's Care Plan for ADL self-care performance deficit care plan, dated 2/22/2023 and last revised on 11/26/2025, revealed shower/baths was listed as: N/A (not applicable). 2.Record review of Resident #2 face sheet, dated 2/19/2026, revealed a [AGE] year-old male admitted on [DATE] with diagnoses which included: paraplegia (paralysis of legs), type 2 diabetes mellitus, and need for assistance with personal care. Record review of Resident #2's 5-day Medicare MDS assessment, dated 1/21/2026, revealed a BIMS score of 15 which indicated he was cognitively intact. His functional status was maximal assistance with shower/bathing and transfers, total dependance on staff for toileting, dressing and use of the wheelchair/movement, moderate assistance for sit to stand and from lying to sitting, and supervision for rolling. Record review of Resident #2's Care Plan for ADL self-care performance deficit, dated 1/20/2026, revealed the plan of care did not identify the resident's ADL needs. The care plan read, encourage to participate to the fullest extent possible with each interaction. During an interview on 2/19/2026 at 3:46 p.m., the MDS Coordinator stated she was new to the facility as of 02/01/2026. The MDS Coordinator stated she was in training and had no prior experience as an MDS Coordinator. The MDS Coordinator stated she was responsible for the care plans. The MDS Coordinator stated her focus was on the skilled residents and not the long-term care residents. The MDS Coordinator stated she was still in training for the long-term care resident care plans. The MDS Coordinator stated she was being trained by someone who came to the facility, but she was unable to identify the person. The MDS Coordinator stated the charge nurses, herself and both the ADON and DON had the ability to alter or adjust the care plans, although the management team wanted to be the ones adjusting them. The MDS Coordinator stated they communicated during morning meetings to review changes. During (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 03/05/2026
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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview on 2/19/2026 at 3:58 p.m., the DON stated residents' care plans were usually updated with the MDS assessment but was not sure within what time frame. The DON stated Resident #1's care plan indicated not applicable for showering and bathing but should reflect the resident's actual care needs, or what was on the MDS assessment which was maximal assistance. The DON stated Resident #2's care plan was never fully developed but should indicate substantial or maximal assistance for bathing/showering and should also match his MDS assessment and actual care needs. The DON stated both care plans were missing information. The DON stated she did not recognize the names of the staff on either care plan, and was not sure why they were missing information. The DON stated an accurate comprehensive care plan was important to the nurses and aides had a baseline of care for the resident so any changes of condition could be identified and interventions put in place. Record review of the facilities policy, titled Comprehensive Person-Centered Care Planning dated12/2023 revealed: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. 4. The facility IDT will develop and implement a comprehensive person-centered, culturally competent, and trauma-informed care plan for each resident within seven (7) days of completion of the Resident Minimum Data Set (MDS) and will include resident's needs identified in the comprehensive assessment .and resident's goals and desired outcomes .

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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 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide residents with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 3 of 3 residents (Resident #1, #2, and #3) reviewed for quality of life. The facility failed to ensure Residents #1, #2, and #3 had hot water in their own showers for showering for a warm and comfortable experience. This failure could place residents at risk for a decline in quality of life and health status. The findings included:1.Record review of Resident #1's face sheet, dated 2/19/2026, revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included: sequelae of cerebral infarction (stroke), vascular dementia without behavioral disturbance (a common form of dementia caused by an impaired supply of blood to the brain, such as may be caused by a series of small strokes), and need for assistance with personal care. Record review of Resident #1's quarterly MDS assessment, dated 11/21/2025, revealed a BIMS score of 00 which indicated the resident's cognition could not be scored and the resident could not be understood. Her functional abilities were maximal assistance with bathing and total dependance on staff for personal hygiene/toileting. Record review of Resident #1's ADL self-care performance deficit care plan, dated 2/22/2023, and last revised on 11/26/2025 revealed shower/baths was listed as: N/A (not applicable). Record review of Resident #1's ADL completed bath activity for the last 30 days revealed the resident was on a Monday, Wednesday, and Friday bathing schedule. There were no showers, baths, or sponge baths documented in the resident's medical record from 1/22/2026-2/19/2026. Record review of Resident #1's shower sheets revealed the following from 1/22/2026-2/19/2026: - shower provided on 1/23/2026- bed bath provided on 1/26/2026- shower provided on 1/28/2026, 1/30/2026. 2/2/2026. 2/04/2026, 2/06/2026, 2/09/26, 2/11/26, 2/13/26, 2/16/26, 2/18/26 Record review of a facility grievance, dated 2/02/2025, by Resident #1's family member revealed No hot water to provide a shower or bath . The grievance indicated it was resolved on 2/02/2026 without indications on how it was resolved. During an observation on 2/18/2026 at 2:54 p.m., with the Maintenance Director obtained water temperatures and revealed the water temperature in the shower inside Resident #1's room was 94 degrees F and the sink temperature was 77 degrees F after running for a full three minutes. During an interview on 2/18/2026 at 3:00 p.m., Resident #1 was unable to answer any interview questions due to her cognitive status. During attempted interviews on 2/18/2026 and 2/19/2026 with Resident #1's family members were unsuccessful. 2.Record review of Resident #2 face sheet, dated 2/19/2026, revealed a [AGE] year-old male admitted on [DATE] with diagnoses which included: paraplegia (paralysis of legs), type 2 diabetes mellitus, and need for assistance with personal care. Record review of Resident #2's 5-day Medicare MDS assessment, dated 1/21/2026, revealed a BIMS score of 15 which indicated he was cognitively intact. His functional status was maximal assistance with shower/bathing. Record review of Resident #2's ADL self-care performance deficit, dated 1/20/2026, revealed the plan of care did not identify the resident's showering/bathing needs. Record review of Resident #2's ADL completed bath activity for the last 30 days from 1/21/2026 to 2/19/2026 revealed:- Refusal of bathing on: 1/23/2026 and 1/30/2026- Full body bath on: 1/23/2026, 1/26/2026, 1/28/2025, 2/05/2026, 2/11/26, 2/13/26, 2/17/26 and 2/18/26- Shower on: 2/13/2026 During an observation on 2/18/2026 at 2:54 p.m., water temperatures were taken by the Maintenance Director and revealed the water temperatures in Resident #2's room shower were 80 degrees F at both the shower and sink after letting the water run for a full three minutes. During an interview on 2/18/2026 at 5:35 p.m., Resident #2 stated there was no hot water in his room for at least 2-3 weeks. The resident stated if the staff was unable to find hot water for him, he refused the shower. The resident stated staff had suggested he could take a shower in another resident's room, but he refused. The resident stated he wanted to shower in his room, not go into other people's room to shower and change. The resident stated he accepted sponge baths multiple times, if the staff (continued on next page)

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	675509	A. Building B. Wing	03/05/2026

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 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	found hot water. The resident stated he preferred to take a shower to feel clean. He stated he would like to have clean hot water in his own room. 3.Record review of Resident #3's face sheet, dated 2/19/2026, revealed a [AGE] year-old male admitted on [DATE] with diagnoses which included: cirrhosis of liver (an advanced, irreversible scarring (fibrosis) of the liver caused by chronic diseases), type 2 diabetes mellitus, and need for assistance with personal care. Record Review of Resident #3's 5-day Medicare MDS assessment, dated 1/14/2026, revealed a BIMS score of 15 which indicated he was cognitively intact. His functional status for showering/bathing was sept-up assistance. Record review of Resident #3's ADL self-care performance deficit care plan, dated 10/10/2025, last revised on 2/12/2026, revealed the resident was dependent on two staff members for bathing/showering. Record review of Resident #3's ADL completed bath activity for the last 30 days, 1/21/2026 to 2/19/2026, revealed:- Shower on: 1/22/2026, 1/24/2026, 1/26/2026, 1/27/2026, 1/29/2026, 1/31/2026, 2/05/2026 and 2/07/2026- Full Body bath on: 2/16/2026 During an observation on 2/18/2026 at 2:54 p.m., water temperatures inside Resident #3's room, taken by the Maintenance Director, revealed shower water temperature of 80 degrees F and sink water temperature of 77 degrees after running for a full three minutes. During an interview on 2/18/2026 at 5:30 p.m., Resident #3 stated he was only taking showers once a week because the water was too cold. The resident stated the staff were aware of the cold water temperatures. Resident #3 stated if he refused a shower the staff just said okay. The resident stated he sometimes accepted a bed bath because it was warmer. The resident stated sometimes, he just cannot stand it and will take a shower even if it was cold. The resident stated he wanted to take warm showers. During an interview on 2/18/2026 at 4:27 p.m., the Maintenance Director stated the facility had an issue with fluctuating water temperatures for the past couple of months. The Maintenance Director stated the hot water problem had stated at the end of December 2025 to the present. The Maintenance Director stated they made repairs to a mixing valve and were in the process of trouble shooting and working on additional solutions. The Maintenance Director stated it was his belief the showers were mixing hot and cold water and replacement cartridges were ordered to hopefully fix the shower concern. The Maintenance Director stated it could take a couple more weeks for the repairs to be completed. The Maintenance Director stated the majority of the rooms affected were on one wing of the facility which included Resident #1, #2 and #3's rooms. The Maintenance Director stated he told staff to let water run. The Maintenance Director stated all facility management was aware of the lack of hot water, including the Administrator. During an interview on 2/18/2026 at 5:40 p.m. CNA A stated some rooms had hot water and some rooms did not. CNA A stated they were taking residents who did not have hot water in their rooms to other residents' rooms of the same gender for showers or finding an empty room with hot water, if available. CNA A stated some residents would refuse to go into other residents' rooms to shower. She stated the sink in the dining room typically had hot water for a bed bath, or they could get hot water from the coffee machine to mix with cold water for a bed bath, or basin/bucket bath. CNA A stated a total body bath was another name for a basin bath, not an actual tub bath. CNA A stated there were some residents who would refuse bed baths if they were not able to obtain hot water. CNA A stated the staff had been instructed to offer alternatives to showers, but some residents refused the alternatives that were offered. CNA A stated they reported the shower refusals to the nurses, and the staff reported maintenance concerns, including water temperature concerns directly to the Maintenance Director. During an interview on 2/19/2026 at 4:50 p.m., LVN B stated there have been multiple resident complaints of hot water brought up by multiple people. LVN B stated Resident #1's family had concerns and others she could not remember. LVN B stated on most days, they exhausted the showers and hot water that were actually working for the day. LVN B stated the CNAs and staff tried to balance it out the best they could. LVN B stated all management staff were aware and the situation was never fully fixed. LVN B stated the staff had been trying to fill up basins with warm water, offer bed baths and find alternative rooms, but once the hot water was out, it was out. LVN B stated there was not enough hot water to go around for all the residents. LVN B stated the (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 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Maintenance Director told them to turn on all the water on the hallway, which she did, and the water was lukewarm at best. During an interview on 2/29/2026 at 4:55 p.m., CNA C stated staff documented showers in the POC (computer). CNA C stated some of the resident rooms did not have any hot water. CNA C stated she handled the lack of hot water by going to a room with hot water and filling containers of hot water. CNA C stated she then takes the resident into their own shower and pours basins of hot water/warm water over the resident, so they feel like they are getting an actual shower. CNA C stated she has reported the lack of hot water to the nurses, the management, and to maintenance. During an interview on 2/19/2026 at 2:54 p.m., the DON stated she was new to the facility by four weeks and was not really sure what the facility was doing or what their process were. The DON stated residents should be showered every other day. The DON stated the facility did not have a bathtub, but the facility had showers and could give a sponge bath or a bed bath as an alternative. The DON stated one used a washcloth to wash the whole body (sponge bath) and one used a bucket of water (head to toe bath) or basin but did not involve running water. The DON stated Resident #1's family had complained about the hot water/showers, however she had not heard of any other complaints. The DON stated she had instructed staff to use an empty room if the hot water in that room was working, to offer a bed bath, and if the resident refused, to notify the nurse and the family. The DON stated she acknowledged that not everyone would be comfortable with a bed bath. The DON stated when talking to Resident #1's family she did not discuss when the hot water issue would be resolved, and only stated, hopefully soon. The DON stated it was her understanding that hot water varied by day and by room. The The DON stated a room with hot water one day might not have it the next day. The DON stated she understood that having to move the location in which a resident showered daily could be confusing to the residents, especially those who had dementia. Record review of the facilities policy, titled Routine Procedures/Bath, Shower dated 05/2007 revealed: It is the policy of this facility to promote cleanliness, stimulate circulation and assist in relation. Dependent Residents: 1. Assist resident to shower room. 2. Adjust water to a comfortable temperature before turning stream toward resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 3 residents (Resident #1) reviewed for medical records accuracy, in that: The facility failed to ensure Resident #1 Nursing Assistant ADL Flow Sheet was accurately documented from 1/21/2026 to 2/19/2026. This failure could place residents at risk for an incomplete clinical picture and errors in care and treatment. The findings included: Record review of Resident #1's face sheet, dated 2/19/2026, revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included: sequelae of cerebral infarction (stroke), vascular dementia without behavioral disturbance (a common form of dementia caused by an impaired supply of blood to the brain, such as may be caused by a series of small strokes), and need for assistance with personal care. Record review of Resident #1's quarterly MDS assessment, dated 11/21/2026, revealed a BIMS score of 00 which indicated the resident's cognition could not be scored and the resident could not be understood. Her functional abilities were maximal assistance with bathing and total dependance on staff for personal hygiene/toileting. Record review of Resident #1's ADL self-care performance deficit care plan, dated 2/22/2023 and last revised on 11/26/2025, revealed shower/baths was listed as: N/A (not applicable). Record review of Resident #1's ADL completed bath activity for the last 30 days revealed the resident was on a Monday, Wednesday, and Friday bathing schedule. There were no showers, baths, or sponge baths documented in the medical record in the last 30 days from 1/22/2026-2/19/2026. Record review of Resident #1's shower sheets, dated 1/22/2026-2/19/2026, revealed the following:-Shower provided on 1/23/2026-Bed bath provided on 1/26/2026-Shower provided on 1/28/2026, 1/30/2026. 2/2/2026. 2/04/2026, 2/06/2026, 2/09/26, 2/11/26, 2/13/26, 2/16/26, 2/18/26 During an interview on 2/19/2026 at 4:07 p.m., the DON stated she did not know if the shower sheets were part of the resident's medical records. The DON stated Medical Records was responsible for documentation uploads. The DON stated it was important to have a complete and accurate medical record so the facility could accurately account for all care the resident received while at the facility. During an interview on 2/19/2026 at 4:16 p.m., Medical Records stated she did not upload shower sheets as part of the resident's medical record. Medical Records stated shower sheets were for facility information only, however she stated she gathered residents' shower sheets and stored them for five years, but they were never uploaded into the medical record. Record review of the facilities policy titled Administration, Content of Medical Record dated 8/2007 revealed: All physicians, nursing staff and other health care professionals involved in the resident's care will be responsible for making prompt, appropriate entries in the record. 6. List of contents of the medical record: Nursing Assistants ADL Flow Sheets.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 2 of 2 floors (2nd and 3rd floors) reviewed for physical environment, in that: The facility failed to ensure hot water temperatures were maintained between 100-110 degrees. This failure could place residents at-risk for uncomfortable water temperatures. The findings included: During an observation on 2/18/2026 at 2:54 p.m. of water temperatures measurements by the Maintenance Director revealed the following temperatures out of range for occupied resident rooms: room [ROOM NUMBER] - shower 118, sink 118 F. room [ROOM NUMBER] - sink 118 F.room [ROOM NUMBER] - sink 118 F.room [ROOM NUMBER] - shower 80, sink 80 F.room [ROOM NUMBER] - shower 91, sink 77 F. room [ROOM NUMBER] - shower 94 F.room [ROOM NUMBER] - shower 77, sink 77.room [ROOM NUMBER] - shower 80, sink 77 F.room [ROOM NUMBER] - shower 80, sink 80 F.room [ROOM NUMBER] - shower 88, sink 80 During an interview on 2/18/2026 at 4:14 p.m., LVN D stated there had not been any complaints of water being too hot. LVN D stated she had instructed the CNAs if water was too hot or too cold to use a basin to mix the water. LVN D stated some residents refused to go without a shower regardless of water temperature. LVN D stated they also tried to find an alternative room with hot water, if available, for a shower. LVN D stated she was not certain if anyone reported the water temperatures either too hot or too cold. LVN D stated they were supposed to report maintenance concerns via the computer but most of the time they just told the Maintenance Director in person. LVN D stated most of the time the Maintenance Director responded to let the water run for a few minutes or find an alternative. During an interview on 2/18/2026 at 4:27 p.m., the Maintenance Director stated since the end of December 2025 to present the facility had fluctuating water temperatures. The Maintenance Director stated he was uncertain what the regulations were for the exact temperature range he was supposed to maintain water temps between. The Maintenance Director stated he had plumbers fix certain issues, although he was unable to state what issues were repaired. The Maintenance Director stated he was unable to provide information to contact any of the plumbers when requested. The Maintenance Director did not respond when asked directly what was on the list of things that needed to be fixed. The Maintenance Director stated facility management, including the Administrator was aware of the water temperature issues in the facility. During an interview on 2/19/2026 at 10:12 a.m., the Administrator stated she was aware that some residents were complaining of lack of hot water. The Administrator stated reviewed and signed off on grievances including the one on 2/2/2026 made by Resident #1's family member. The Administrator stated the water temperature issue had been a known facility issue since the end of December 2025, and the facility had plumbers come to the facility several times. The Administrator stated they educated the CNA's that if they did not have hot water in the area where they were working to utilize other areas of the facility, such as another resident room or another method of bathing such as a bed bath with warm water. The Administrator stated the staff could get warm water because it was not a consistent problem. The Administrator stated her expectation of the Maintenance Director was to check water temperatures daily on random rooms, at random times and problem solve, notify/communicate to the department heads and to let the nurses know of the situation. The Administrator stated the Maintenance Director should respond to complaints of irregular water temperatures. The Administrator stated she was unsure what the regulations indicated for range of hot water temperatures. The Administrator stated having water temperatures within regulatory limits was important for the comfort of the residents because it was their home. During an interview on 2/19/2026 at 4:59 p.m., the DON stated the facility did not have a policy for water temperatures or physical environment. Record review on 03/05/2026 of the Facility Maintenance Water Temperature log dated 01/12/2026 revealed the following:Resident room [ROOM NUMBER] measured 80 degrees (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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	FahrenheitResident room [ROOM NUMBER] measured 94 degrees FahrenheitResident room [ROOM NUMBER] Measured 82 degrees FahrenheitResident room [ROOM NUMBER] Measured 80 degrees FahrenheitResident room [ROOM NUMBER] Measured 82 degrees FahrenheitResident room [ROOM NUMBER] Measured 80 degrees FahrenheitResident room [ROOM NUMBER] Measured 80 degrees FahrenheitResident room [ROOM NUMBER] Measured 82 degrees FahrenheitResident room [ROOM NUMBER] Measured 81 degrees FahrenheitResident room [ROOM NUMBER] Measured 81 degrees Fahrenheit Record review on 03/05/2026 of the Facility Maintenance log reflected an active repair floor plan of all the resident rooms affected by the fluctuating water temperatures.Findings included:Resident room [ROOM NUMBER]Resident room [ROOM NUMBER]Resident room [ROOM NUMBER]Resident room [ROOM NUMBER]Resident room [ROOM NUMBER]Resident room [ROOM NUMBER]Resident room [ROOM NUMBER]Resident room [ROOM NUMBER]Resident room [ROOM NUMBER]Resident room [ROOM NUMBER]Resident room [ROOM NUMBER]Resident room [ROOM NUMBER]Resident room [ROOM NUMBER]Resident room [ROOM NUMBER]Resident room [ROOM NUMBER]Resident room [ROOM NUMBER]Resident room [ROOM NUMBER]Resident room [ROOM NUMBER] During an interview with the Administrator on 03/05/206 at 11:35 a.m., the Administrator stated the facility's water problems had been an ongoing issue for several months. The Administrator stated only the resident rooms are affected as the kitchen and laundry are on a separate boiler. The Administrator stated there had been several repairs done over the last several months, and the facility was in the process to get bids to replace the whole boiler so their water system would be independent of the building they were currently connected to. During an interview on 03/05/2026 at 3:45 p.m., the Facility Maintenance Director confirmed and stated the resident rooms located on the first and second floors were recording fluctuating water temperatures. Additionally, he stated he was actively replacing the cartridges in all the water fixtures throughout the first and second floor to alleviate the rising and dropping water temperatures. When asked how long the facility had been having issues with the water temperatures, he stated that back in January of 2026 was when they first started experiencing the changes in temperatures. When asked who was responsible for maintaining the water temperatures throughout the facility he stated he was responsible. Additionally, he stated the facility had ordered a large amount of replacement pressure balance cartridges for the water fixtures located inside resident rooms and the Maintenance Department was actively replacing them with the new ones. He stated that replacing the cartridges in the rooms has drastically improved the water temperatures and is helping meet compliance throughout the facility. After further discussion it was agreed that not maintaining the water temperatures in resident rooms throughout the facility could cause scalding or other physical injuries to residents and staff. During an interview on 03/05/2026 at 4:30 p.m., the Regional Maintenance Director stated the facility had been struggling with maintaining water temperatures throughout the facility. When asked how long the facility had undergoing fluctuating water temperatures, he stated since January of 2026. Additionally, he stated the water towers, and boilers for the facility were in a mechanical room located in the neighboring independent living facility. He stated maintaining proper water temperatures has been a struggle since the independent living facility staff members are always adjusting the boilers without their discretion. When asked who was responsible for maintaining the water temperatures throughout the facility, he stated the facility maintenance department was responsible. When asked what plan the facility had created to correct the issue he stated the facility was actively checking water temperatures daily while bids for installing a new boiler and water tower connected to the Nursing Home branched away from the independent living with their own water meter were under review. He stated the facility had an additional bid for replacing the boilers. Additionally, he stated the process to get the bid approved from admission staff is a lengthy process but has plans to resolve the issue as soon as possible. He stated the facility had ordered a large amount of replacement pressure balance cartridges for the water fixtures located inside resident rooms and the Maintenance Department was actively replacing them with the new ones. He stated that replacing the cartridges in the rooms has drastically improved (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 03/05/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the water temperatures and is helping meet compliance throughout the facility. After further discussion it was agreed that not maintaining the water temperatures in resident rooms throughout the facility could cause scalding or other physical injuries to residents and staff. Record review of invoice from plumbing company, dated 01/07/2026, for repair to a recirculation line on the facility's hot water system. Record review of invoice from plumbing company, dated 01/22/2026, revealed plumbers came to the facility for, an estimate to install a whole new boiler system for domestic hot water. Record review of invoice from plumbing company, dated 01/27/2026, for a quote to replace mixing valves. Record review of invoice from plumbing company, dated 01/27/2026, for adjustment of mixing valve in the boiler room. Record review of invoice from plumbing company, dated 02/05/2026, for adjustment of mixing valve in boiler room. Record review of invoice from parts company, dated 02/18/2026, for plumbing parts to include: 71 pressure balance cartridges, four faucets, and an adjustable wrench.