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	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parklane West Healthcare Center	2 Towers Park Lane 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 interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs that were identified in the comprehensive assessment, and described services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 10 residents (Resident #1) reviewed for care plans. The facility failed to ensure Resident #1's care plan was updated to reflect Resident #1 had an incident of resident-to-resident verbal altercation on 04/17/2026. This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs. The findings included:Record review of Resident #1's face sheet, dated 06/02/2026, revealed the resident was a [AGE] year-old female, originally admitted to the facility on [DATE], and readmitted [DATE] with diagnoses of traumatic subdural hemorrhage with loss of consciousness (a bleed around the brain), dementia (loss of memory and thinking ability), and adjustment with mixed anxiety and depressed mood disorder. Record review of Resident #1's quarterly MDS assessment, dated 03/02/2026, revealed the resident's BIMS score was 4 out of 15 which indicated the resident had severe cognitive impairment and was receiving antianxiety and antidepressant as ordered in Section N (Medications). Record review of Resident #1's Incident and Accident Report, dated 04/17/2026, revealed LVN-A saw Resident #1 was yelling to her roommate and said that her roommate was her granddaughter and asked sitting down on the chair, but her granddaughter (Resident #1's roommate) did not listen to Resident #1. The facility staff immediately separated Resident #1 from her roommate and notified the resident's primary care physician and DON. Further record review of the Incident and Accident Report revealed the facility had IDT meeting, changed Resident #1's room, made Resident #1 to receive psychiatric evaluation and treatment as ordered, and conducted urinalysis. Record review of Resident #1's comprehensive care plan, dated 10/27/2025, revealed the resident had the care plan of [Resident #1] has a history of hallucinations of accusing related to confusion and dementia. For intervention - Administer medications as ordered. Monitor/document for side effects and effectiveness. Further record review of the comprehensive care plan revealed there was no updated care plans regarding resident-to-resident verbal altercation on 04/17/2026, room changed, urinalysis, and psychiatric evaluation and treatment. Interview on 06/04/2026 at 2:45 p.m. with MDS nurse LVN-B said that she had responsibility to update Resident #1's care plan regarding resident-to-resident verbal altercation on 04/17/2026 but did not update the resident's care plan because she started working on April 2026 so might have missed updating the incident. MDS nurse LVN-B said she should have updated Resident #1's care plan regarding the resident-to-resident verbal altercation on 04/17/2026 after the IDT meeting because updating the care plan played a leading role as a communication tool among staff and providers. Interview on 06/05/2026 at 1:00 p.m. with DON said Resident #1's comprehensive care plan should have been updated regarding the resident-to-resident verbal altercation on 04/17/2026 after the IDT meeting, and if the care plan was not updated, the resident might receive inappropriate care. Record review of (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
	675509	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parklane West Healthcare Center	2 Towers Park Lane 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	the facility policy, titled Comprehensive person-centered care planning, undated, revealed . 5. The resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment and as needed. Interventions put in place are to follow as the plan of care for the resident. These interventions may be adjusted or resolved as needed to facilitate the resident needs.

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	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parklane West Healthcare Center	2 Towers Park Lane 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident who is incontinent of bladder receives appropriate treatment and service to prevent urinary tract infections for 1 (Resident #2) of 2 residents reviewed for incontinent care in that: CNA-C and CNA-D placed Resident #2's indwelling urinary catheter bag above the level of the resident's bladder during transferring the resident from the bed to the wheelchair mechanically on 06/03/2026. This failure placed resident at risk for urinary tract infection, unwanted antibiotic therapy, and decrease in quality of life. Findings:Record review of Resident #2's face sheet, dated 06/05/2026, revealed the resident was a [AGE] year-old male, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnoses of paraplegia (inability to voluntarily move the lower parts of the body), urinary tract infection (infection in any parts of the urinary system such as kidney, ureters, or bladder), and cystitis (inflammation of the bladder). Record review of Resident #2's quarterly MDS assessment, dated 04/23/2026, revealed the resident's BIMS score was 15 out of 15 which indicated the resident's cognition was intact and had an indwelling urinary catheter in the Section H (Bladder and Bowel). Record review of Resident #2's comprehensive care plan, dated 11/17/2025, revealed the resident had the care plan of [Resident #2] Has Suprapubic Catheter (urinary catheter that is inserted into the bladder from a small cut in the tummy, just above pubic bone) for Neurogenic bladder (the bladder does not empty, properly due to a neurological condition). For intervention - CATHETER: Position catheter bag and tubing below the level of the bladder and away from entrance room door. Observation on 06/03/2026 at 1:47 p.m. revealed that CNA-C and CNA-D put the sling under Resident #2 and attached the sling to the mechanical lift. When the mechanical lift raised the resident, CNA-C was holding the resident's catheter bag in the air above the level of the resident's bladder. Further observation revealed when Resident #2 was in the air and transferred from the bed to the wheelchair by the mechanical lift, and CNA-C was holding the resident in the air, CNA-D also was holding the resident's catheter bag in the air above the level of the resident's bladder. Interview on 06/03/2026 at 2:02 p.m. with CNA-C and CNA-D said they positioned Resident #2's catheter bag above the level of the resident's bladder during mechanical lift transfer because they were confused and nervous. CNA-C and CNA-D stated they should have positioned the catheter bag below the level of the resident's bladder all the time to prevent urine from flowing back to the bladder and possible infection. CNA-C and CNA-D said they received education and had skill check-off yearly regarding how to take care of the catheter bag during transfer. Interview on 06/03/2026 at 5:00 p.m. with DON said CNA-C and CNA-D should have positioned Resident #2's catheter bag below the level of the resident's bladder all the time during the mechanical lift transfer to prevent urine from flowing back to the bladder and possible infection. Record review of the facility policy, titled Catheter Drainage Bag, dated 12/2023, revealed . 14. Position the drainage bag below the level of the resident's bladder and without resting on the floor. Ensure tubing allows for unobstructed drainage of urine.

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	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parklane West Healthcare Center	2 Towers Park Lane 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, in accordance with State and Federal laws, to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 2 (3rd floor medication aide cart and 2nd floor nursing cart) of 4 medication carts reviewed for medication storage. 1. The facility failed to ensure MA-E locked the 3rd floor medication aide cart when it was unattended on 06/03/2026. 2. The facility failed to ensure LVN-F locked the 2nd floor nursing cart when it was unattended on 06/04/2026. These failures could place residents at risk of not receiving prescribed medications as ordered and drug diversions. Findings Included:1. Observation on 06/03/2026 at 11:44 a.m. revealed there was one medication aide cart in front of the 3rd floor nursing station, and the cart was observed unlocked, unattended, and no staff were around the cart. Interview on 06/03/2026 at 11:57 a.m. with MA-E said she forgot to lock her cart when she left the cart for break, and it was her mistake. MA-E said she should have locked her cart all the time to prevent possible drug diversions. 2. Observation on 06/04/2026 at 3:00 p.m. revealed there was one nursing cart in front of the 2nd floor nursing station, and the cart was observed unlocked, unattended, and no staff were around the cart. Interview on 06/04/2026 at 3:04 p.m. with LVN-F said she forgot to lock her cart when she went to some resident's room for care, and it was her mistake. LVN-F said she should have locked her cart all the time to prevent possible drug diversions and somebody taking some medication. Interview on 06/04/2026 at 5:00 p.m. with DON said the facility Nurses and Medication Aides should have locked their carts all the time to prevent somebody from taking medications and possible drug diversions, and locking medication carts were their responsibilities Record review of the facility policy, titled Medication access and storage, undated, revealed . 2. 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.