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	05/16/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131 Based on observations, interviews, and record review, the facility failed to ensure that residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 of 6 residents (Resident #29) reviewed for call lights. The facility failed to ensure Resident #29's call light was within reach. This failure could place residents at risk of achieving independent functioning, dignity, and well-being. Findings include: Record review of Resident #29's face sheet dated 5/14/25 revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #29 had diagnoses that included Major Depressive Disorder (a severe mood disorder that can affect a person's thoughts, feelings, and ability to perform daily activities), Dementia (a decline in cognitive function, including thinking, remembering, and reasoning, severe enough to interfere with daily life) and Diabetes Mellitus (is a metabolic disorder characterized by persistently high blood sugar levels). Review of Resident #29 Quarterly MDS assessment, dated 2/10/25, reflected under section G, G0300, option # 3, which stated that the patient was unsteady on their feet, and required assistance X 2. Record review of Resident #29's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 7, which indicated severe cognitive impairment. Record review of Resident #29's care plan, revised 7/25/2024, revealed a care plan with a focus at risk for falls related to muscle weakness, and interventions included to ensure the call light was within reach. Observation and interview on 5/14/25 in Resident #29's room at 11:40 AM revealed that the call light was found on the floor under the bed, Resident was in bed. Resident #29 stated, I yell for help, here. Resident #29 said she did not know how the call light ended up on the floor. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/14/25 at 11:50 AM, ADON stated that he was the assigned nurse for Resident #29. He mentioned that he did not know how Resident #29's call light ended up on the floor, but he picked it up and clipped it to Resident #29's bedspread. He also noted that if Resident #29 lacked access to the call light, it could potentially lead to a fall if Resident #29 needed assistance. During an interview with the DON on 5/16/25, at 1:14 PM, she emphasized the importance of ensuring that the call light was accessible to all residents. She stated that the lack of accessibility to a call light for any resident could lead to a potential negative outcome if assistance was needed. The DON also mentioned that charge nurses currently monitored that task during their daily morning rounds, and she oversees this process. Record review of facility policy Call Light/ Bell,dated 5/2007, revealed, place the call light with in the residents reach before leaving room.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41651 Based on interview and record review, the facility failed to ensure the residents' right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive for 1 (Resident #28) of 33 residents reviewed for advanced directives, in that: Resident #28's OOH-DNR was missing a physician's signature and was therefore invalid. This deficient practice could place residents at-risk of having their end of life wishes dishonored and of having CPR performed against their will. The findings were: Record review of Resident #28's face sheet, dated [DATE], revealed the resident was admitted to the facility on [DATE] with diagnoses including end stage renal disease and dependence on renal dialysis. Record review of Resident #28's Quarterly MDS, dated [DATE], revealed a BIMS score of 14 which indicated intact cognition. Record review of Resident #28's care plan, revised [DATE], revealed, [Resident #28] has elected DNR status. Record review of Resident #28's OOH-DNR form, revealed the resident signed the form on [DATE]. Further review revealed the physician signed the upper portion of the form on [DATE] but failed to sign the lower portion of the form. During an interview with the Social Worker on [DATE] at 4:42 p.m., the Social Worker confirmed that two signatures were required for all parties who sign an OOH-DNR form, confirmed the physician signature was missing from the lower portion of the form, and confirmed the missing signature rendered the form invalid. The Social Worker stated it was her responsibility to ensure OOH-DNR forms were correctly executed and stated the invalid form was an oversight. During an interview with the DON on [DATE] at 12:16 p.m., the DON stated that she expected all advance directives, including OOH-DNR forms to be correctly executed so that the residents' end of life wishes would be honored. Record review of the Texas Health and Human Services webpage titled, Out of Hospital Do Not Resuscitate Program, updated [DATE], revealed, Frequently Asked Questions for DNR: What happens if the form is not filled out correctly or EMS has doubts about any of the information? Health professionals can refuse to honor a DNR if they think: The form is not signed twice by all who need to sign it or is filled out incorrectly. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy, Advanced Directives and Associated Documentation, reviewed [DATE], revealed, It is the policy of this facility that a resident's choice about advanced directives will be recognized and respected.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131 Based on observation, interview, and record review, the facility failed to ensure residents had the right to personal privacy and confidentiality of his or her personal and medical records for 1 of 5 residents (Resident #72) reviewed for privacy, in that: The facility failed to ensure that MA D locked the computer after she walked away and left the computer unattended , which exposed Resident #72's morning medication list . This failure could place residents at risk of having their medical information exposed to others and cause residents to feel uncomfortable and disrespected. The findings include: Record review of Resident #72's face sheet dated 5/14/25 reflected an [AGE] year-old resident who was admitted to the facility on [DATE] with diagnoses which included: Chronic Obstructive Pulmonary Disease (lung disease that damages the airways or other parts of the lungs, making it difficult to breathe), Heart Failure (condition in which the heart isn't pumping as well as it should) and Atrial Fibrillation (an irregular and often very rapid heart rhythm that can lead to blood clots). Record review of Resident #72's Quarterly MDS assessment, dated 2/26/25, reflected a BIMS score of 9, which indicated moderate cognitive impairment. Observation on 5/14/24 at 9:20 AM, revealed MA D prepared Resident's #72's morning medication and, walked away from the computer leaving screen facing fall , MA D did not lock the computer screen and was away from computer for 7 minutes. During an interview on 5/14/24 at 9:40 AM, MA D stated she was not aware of the option to lock the computer screen and believed minimizing the screen was sufficient. MA D noted Resident #72's private medical information might have been exposed when she stepped away from the computer. During an interview on 05/15/24 at 1:51 PM, the DON stated she was unaware that Resident #72's records had been left open and unattended by MA D. The DON stated her expectation was for the facility nursing staff to uphold HIPAA regulations and lock computer screens when they were away from them. The DON emphasized that all staff members should protect residents' information. The DON expressed concern that leaving residents' charts open and unattended could lead to unauthorized access. The DON also stated that the ADON would be responsible for overseeing compliance with this task, and she would monitor it by conducting random computer screen checks. Record review of the facility's undated policy titled HIPAA reflected: Protected health information that identifies a patient/resident or contains information that can be used to determine the patient/resident must be kept safe, confidential, and protected.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27923 Based on observation, interview, and record review, the facility failed to ensure the residents had a right to a safe, clean, comfortable, and homelike environment for 3 (Residents #147, #148 and #207) of 32 residents reviewed, in that: 1. The bathroom shower faucet handle used by Resident #147 and Resident #148 was broken. 2. The toileting chair used by Resident #207 had a rusty metal support frame with peeling paint in front of and under the seat. This failure could result in psychosocial harm due to diminished quality of life. The findings included: 1. Record review of Resident #147's face sheet, dated 5/16/25, revealed the [AGE] year resident was admitted to the facility on [DATE] with diagnoses including: obstructive hydrocephalus (a condition in which cerebrospinal fluid is blocked in the brain), hypotension (a condition of low blood pressure), and anxiety disorder (a condition in which there is excessive worry about every- day situations). 2. Record review of Resident #148's face sheet dated 5/16/25, revealed the [AGE] year old resident was admitted on [DATE] with diagnoses including: unspecified severe protein-calorie malnutrition (a condition in which there is a significant lack of protein and calories in the body), anemia (a condition in which there is not enough healthy red blood cells), and cognitive communication deficit (a condition in which communication is difficult because of a cognition problem) Record review of Resident #147's Quarterly MDS, dated [DATE], revealed a BIMS score of 11 which indicated moderate cognitive impairment. Record review of Resident #148's Quarterly MDS, dated [DATE], revealed a BIMS score of 14 which indicated intact cognition. Record review of Resident #147's care plan, initiated 07/4/2024, revealed resident had impaired cognitive functioning and was considered a fall risk Record review of Resident #148's care plan, initiated 7/29/24, revealed resident had impaired cognitive functioning and impaired communication. During an interview with the Administrator on 05/13/25 at 10:10 am he revealed that the facility's Maintenance Director's position was vacant. Observation on 05/14/25 at 10:05 am for Resident #147 and #148 revealed there was not a shower handle on the shower in the bathroom. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/15/25 at 10:10 am with Resident #148 he stated that the shower handle had been broken in his bathroom for at least 2 weeks. He stated that he was told the shower handle was leaking and had to be removed. Resident #148 stated he had to use the bathroom shower across the hallway and would feel happier if his own bathroom shower was repaired. During an interview on 05/15/25 at 10:15 am with Resident #147 he stated that his bathroom shower handle had been broken for over a month. He stated he was told by the Maintenance Director that it would be fixed. Resident #147 stated that he had to use the shower in the resident's room across the hallway. During an interview with LVN-A on 5/14/25 at 10:30 am she stated she was not aware Resident's #147 and #148 were using the resident's bathroom shower across the hallway. LVN-A stated that she checked the work order report and noted a request for a shower handle replacement was placed in the TELS work order system on 4/5/25, 4/13/25, and 4/14/25. During an interview CNA-B on 05/14/25 at 10:35 am she stated she was aware that Residents #147 and 148 had to use the resident's bathroom shower across the hallway since their own bathroom shower handle was broken. She stated that both residents are ambulatory, take daily showers, and had coordinated with the resident in the adjoining room to use that resident's bathroom shower. Record review of the facility's TELS work order requests revealed requests on 4/5/25, 4/13/25, and 4/14/25 for bathroom shower handle replacement to be used by Residents #147 and #148. 3. Record review of Resident #207's face sheet revealed a [AGE] year-old resident admitted [DATE] with diagnoses which included: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (weakness or paralysis on one side of body caused by stroke); morbid obesity (severe form of obesity with body mass index of 40 or higher); and urinary tract infection (infection of the urinary tract). Record review of Resident #207's 5-day MDS dated [DATE] revealed she had a BIMS score of 06 indicating moderate cognitive impairment and was assessed as having a urinary tract infection in past 30 days and morbid obesity. Record review of Resident #207's Care Plan initiated 05/05/2025 revealed a focus area for ADL Self Care Performance Deficit r/t weakness and impaired mobility, with interventions which included requires staff participation with bed to chair and toilet transfers. During an interview and observation with Resident #207 on 05/15/2025 at 10:37 AM, Resident #207 complained of the toileting chair she had initially been given to use, noting it was rusty and had peeling paint, and when she used the toileting chair, the peeling paint would scrape against her skin and get into her private parts. She also reported that the toileting chair was too small for her to use, and only after complaining to several staff over several days was she finally provided a larger toileting chair made of PVC pipe, but stated that the original rusty chair was still in her bathroom. She stated she was afraid it would be given to other residents to use in that condition. Observation of Resident #207's bathroom revealed the toileting chair with a rusty metal support frame and peeling paint in front of the seat, was pushed against the side of the bathroom and a larger bariatric toileting chair made of PVC type material was positioned over the toilet. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and observation with LVN-C of Resident #207's bathroom on 05/16/2025 at 08:5. revealed Resident #207 had left the facility AMA last night. Observation of the bathroom that had been used by Resident #207 with LVN-C revealed the toileting chair with the rusty support frame next to the seat was still in the bathroom. LVN-C stated that she was not aware of the condition of the toileting chair, and that it was not acceptable to have a rusty frame that could come into contact with resident as it could not be cleaned/sanitized thoroughly. LVN-C stated it would have been the responsibility of the nurses and CNAs who worked with Resident #207 to put in a work request in TELS for it to be repaired or replaced. LVN-C stated they did not currently have a maintenance director, but thought someone should be covering the work orders, just did not know who that was. During an interview and observation with the Administrator on 05/15/2025 at 09:10 a.m., the Administrator observed the rusty toileting chair and stated that was unacceptable as it could not be cleaned well and was rusty and should be replaced. The Administrator stated staff working with Resident #207 should have put in a work request in TELS to have the shower chair repaired/replaced, but also noted that they do not have a current maintenance director, so he and the Maintenance Supervisor from their regional and sister facilities had been filling in. The Administrator immediately removed the toileting chair, and stated he will have a replacement chair provided. Record review of the facility's TELS work order requests revealed there were no requests in April and May 2025 for repair or replacement of the toileting chair. Record review of the facility's policy entitled Equipment Inspection and Maintenance dated 07/18 revealed It is the policy of this community to maintain all equipment provided by the facility, in good working order to ensure the safety and wellbeing of all residents and staff. 33866

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41651 Based on interview and record review, the facility failed to assess each resident using the quarterly review instrument specified by the State and approved by CMS in a timely manner for 3 (Resident #54, #40, and #81), of 33 residents reviewed for timely assessment, in that: 1. Resident #54's Quarterly MDS, dated [DATE] and Annual MDS, dated [DATE] had been initiated but not completed. 2. Resident #40's Quarterly MDS, dated [DATE] and Quarterly MDS, dated [DATE] had been initiated but not completed. 3. Resident #81's Quarterly MDS, dated [DATE] had been initiated but not completed. This failure could lead to residents not receiving necessary, complete, or correct care due to lack of current information. The findings were: 1. Record review of Resident #54's face sheet, dated 05/16/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus with Hyperglycemia and Muscle Weakness. Record review of Resident #54's clinical record, as of 05/14/2025, revealed a list of MDS assessments beginning with the resident's admission. Review of Resident #54's MDS assessments list revealed his Quarterly MDS, dated [DATE] and Annual MDS, dated [DATE] had both been initiated but were not completed. 2. Record review of Resident #40's face sheet, dated 05/16/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side and Other Speech and Language Deficits Following Cerebral Infarction. Record review of Resident #40's clinical record, as of 05/14/2025, revealed a list of MDS assessments beginning with the resident's admission. Review of Resident #40's MDS assessments list revealed his Quarterly MDS, dated [DATE] and Quarterly MDS, dated [DATE] had both been initiated but were not completed. 3. Record review of Resident #81's face sheet, dated 05/16/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses including Fracture of Unspecified Part of Neck of Right Femur and Type 2 Diabetes Mellitus Without Complications. Record review of Resident #81's clinical record, as of 05/14/2025, revealed a list of MDS assessments beginning with the resident's admission. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #81's MDS assessments list revealed her Quarterly MDS dated [DATE], had been initiated but was not complete. During an interview with MDS C on 05/15/2025 at 2:54 p.m., MDS C confirmed the MDS assessments had been initiated but not completed and stated this was due to an oversight. MDS C stated that MDS assessments should be completed and exported to CMS so that residents may receive services and to aid in the care planning process and confirmed this duty was her responsibility. During an interview with the DON on 05/16/2025 at 12:16 p.m., the DON stated that she expected MDS assessments to be initiated, completed, and exported to CMS in a timely manner. Record review of the facility policy, Resident Assessment and Associated Processes reviewed January 2022, revealed, The facility will electronically transmit encoded, accurate, and complete MDS data to the CMS system .

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on interview and record review, the facility failed to encode and transmit resident assessments in a timely manner for 3 (Residents #200, #57, and #33) of 33 reviewed for resident assessments, in that: 1. Resident #57's Quarterly MDS, dated [DATE], was completed but not transmitted to CMS as of 05/14/2025. 2. Resident #33's Quarterly MDS, dated [DATE], was completed but not transmitted to CMS as of 05/14/2025. 3. Resident #200's Entry MDS, dated [DATE] was completed, but not transmitted to CMS within 14 days of completion. These deficient practices placed residents at risk of not having assessments completed and submitted in a timely manner as required. The findings were: 1. Record review of Resident #57's face sheet, dated 05/16/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Lupus Anticoagulant Syndrome. Record review of Resident #57's clinical record, as of 05/14/2025, revealed a list of MDS assessments beginning with the resident's admission. Review of Resident #57's MDS assessments list revealed his Quarterly MDS, dated [DATE] has been completed but not transmitted to CMS and had a status of export ready. 2. Record review of Resident #33's face sheet, dated 05/16/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus with Diabetic Neuropathy and Unspecified Sequelae of Cerebral Infarction. Record review of Resident #33's clinical record, as of 05/14/2025, revealed a list of MDS assessments beginning with the resident's admission. Review of Resident #33's MDS assessments list revealed his Quarterly MDS, dated [DATE] has been completed but not transmitted to CMS and had a status of export ready. 3. Record review of Resident #200's face sheet dated 05/14/2025 revealed an admitted [DATE] with diagnoses which included Fracture of neck of right femur (a break in the thigh bone); aftercare following joint replacement surgery and essential hypertension (high blood pressure). Record review of Resident #200's Entry MDS assessment revealed it was completed on 04/30/2025, but its status as of 05/16/2025 was noted as export ready. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with MDS C on 05/15/2025 at 2:54 p.m., MDS C confirmed the MDS assessments had been completed but not transmitted to CMS and stated this was due to an oversight. MDS C stated that MDS assessments should be completed and exported to CMS so that residents may receive services and to aid in the care planning process and confirmed this duty was her responsibility. During an interview with the DON on 05/16/2025 at 12:16 p.m., the DON stated that she expected MDS assessments to be initiated, completed, and exported to CMS in a timely manner. During an interview with the DON and Administrator on 05/16/2025 at 12:16 p.m., the DON stated that the Entry MDS needed to be transmitted within 14 days of admission and stated Resident #200's Entry MDS was export ready, meaning it was complete but had not been transmitted yet. The DON stated it was the MDS Nurse's responsibility for transmitting the MDS assessments, however she stated they were short an MDS Nurse right now, and that the delay in transmitting was due to them having only have one MDS Nurse right now. She stated she used to be the second MDS Nurse, but that position has been vacant since she was promoted to the DON position, but noted the position has been posted. The DON stated that by not transmitting the MDS entry assessment within the 14 days, it could hinder monitoring changes in the resident's status and affects reimbursement. Record review of the facility policy, Resident Assessment and Associated Processes reviewed January 2022, revealed, The facility will electronically transmit encoded, accurate, and complete MDS data to the CMS system . 41651

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131 Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 20 residents (Resident #72) reviewed for assessments: Resident #72's quarterly MDS, dated [DATE], did not include a diagnosis of depression. This failure could place residents at risk for inadequate care due to inaccurate assessments. The findings included: Record review of Resident #72's face sheet dated 5/14/25 reflected an [AGE] year-old resident who was admitted to the facility on [DATE] with diagnoses which included: Chronic Obstructive Pulmonary Disease (lung disease that damages the airways or other parts of the lungs, making it difficult to breathe), Heart Failure (condition in which the heart isn't pumping as well as it should) and Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) Record review of Resident #72's monthly physician orders, dated 05/15/2025, revealed the resident had medication order for Buspirone 5 mg tablet (depression medication) and Escitalopram 10 mg tablet (depression medication) both with start date of 12/13/2024. Record review of Resident #72's medication administration record, from 05/01/2025 to 05/15/2025, revealed the resident was receiving Buspirone 5 mg tablet and Escitalopram 10 mg tablet as ordered. Record review of Resident #72's Quarterly MDS assessment, dated 2/26/25, reflected a BIMS score of 9, which indicated moderate cognitive impairment Interview on 05/15/2025 at 2:43 p.m. with MDS nurse confirmed, Resident #72 was receiving Buspirone 5 mg and Escitalopram 10 mg tablet, both for depression. She added that the diagnosis of depression should have been included on the MDS assessment for Resident #72 and was not included as an oversight, which would cause inaccurate billing for the facility to include Resident #72's treatment needs. Interview with the DON on 5/15/25 at 3:30 PM revealed the MDS nurse should have included Resident #72's diagnosis of depression on the MDS assessment to improve care quality and reimbursement outcomes. Record review of the facility policy, titled Resident Assessments, 11/2016, revealed that An accurate Comprehensive Assessment will be made of the residents' needs and will include the following: disease diagnosis and history.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131 Based on interviews and record review, the facility failed to identify a diagnosis of mental illness on the preadmission screening and resident review (PASRR) assessment for 3 of 3 residents (Resident #34 , Resident #55, and Resident #74) whose records were reviewed for PASRR services. The facility failed to recognize during the Level I PASRR screening that Resident #34 and Resident #55 were diagnosed with major depressive disorder, while Resident #74 was diagnosed with schizoaffective disorder and bipolar disorder. This deficient practice could place residents with mental illness at risk for not obtaining the services needed to treat their mental health diagnosis. The findings included: 1. Record review of Resident #34's admission sheet, dated 5/14/25, noted a [AGE] year-old resident admitted to the facility on [DATE] with a diagnoses of major depressive disorder. Record review of Resident #34's quarterly MDS assessment, dated 2/5/25, noted that the resident's BIMS was 15, indicating intact cognition. The MDS reflected psychiatric / mood disorder , depression other than bipolar was selected. Record review of Resident #34's order summary from May 2025 indicated the resident received fluvoxamine 50mg for major depressive disorder at bedtime. Record review of Resident #34's care plan, revised on 11/01/24, revealed the resident is on antidepressant medication, one approach was to monitor and document targeted behavior. Record review of Resident #34's PASRR 1 screening dated 1/24/20, revealed an answer of 0 (No) in section C0100 Mental Illness in response to the question, Is there evidence or an indicator this is an individual with a Mental Illness? 2. Record review of Resident #55's admission sheet, dated 5/14/25, noted a [AGE] year-old resident admitted to the facility on [DATE] with a diagnosis of major depressive disorder. Record review of Resident #55's quarterly MDS assessment, dated 3/22/25, noted the resident's BIMS was 06, indicating severe cognitive impairment. The MDS reflected psychiatric/mood disorder, depression other than bipolar, selected. Record review of Resident #55's order summary from May 2025 indicated the resident received paroxetine 30 mg at bedtime for major depressive disorder. Record review of Resident #55's care plan, revised on 11/01/24, revealed the resident had Potential for mood problem related to disease process with interventions to administer medications as ordered. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #55's, PASRR 1 screening dated 12/18/23, revealed an answer of 0 (No) in section C0100 Mental Illness in response to the question, Is there evidence or an indicator this is an individual with a Mental Illness? 3. Record review of Resident #74's face sheet, dated 5/16/25, revealed the [AGE] year old resident was admitted to the facility on [DATE] with diagnoses including: schizoaffective disorder (a mental health condition that is marked by a mix of symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression) and bipolar disorder (mental disorder that includes bouts of hypomania or mania and sometimes major depression). Record review of Resident #74's Quarterly MDS assessment , dated 03/31/25, revealed a BIMS score of 5, which indicated a low level of cognitive impairment. Record review of the quarterly MDS for Resident #74 revealed a diagnosis of schizoaffective disorder and bipolar disorder. Record review of Resident #74's monthly physician order's for May 2025 revealed Resident #74 was taking an anti-psychotic medication, Seroquel 100mg, each day and at bedtime, for a schizoaffective disorder. Record review of Resident #74's PASRR 1 screening form dated 12/31/23 revealed an answer of 0 (No) in section C0100 Mental Illness in response to the question, Is there evidence or an indicator this is an individual with a Mental Illness? In an interview on 05/16/25 at 12:55 PM, the MDS nurse stated, When residents come here, they should have their PASRR included with their admission paperwork. The MDS coordinator explained that the facility uploads it and sends a copy to the local authority. If the level one screening is negative, the local authority acknowledges receipt. If it is positive, they assess the resident and attend care plan meetings; if negative, there is no follow-up. Regarding whether the PASRR assessment should be left as 'No' for residents with bipolar disorder, major depressive disorder, or schizoaffective disorder, the coordinator stated, Most of the time the PASRR says 'No', and they submit the hospital PASRR to the local authority and the MDS assessment. When asked about the risk of putting 'No' on the level one screening for residents with mental illness, the MDS Coordinator said she has never experienced a negative effect if they answer 'No', as behaviors lead to mental screenings. Lastly, she noted no issues arise from not marking 'Yes' for mental illness, as psych services are available on-site. In an interview on 05/16/25 at 1:20 PM with the DON, she stated she would consult with corporate leadership about training for the MDS nurse because the residents have a mental illness diagnosis on admission. Still, the hospital PASRR assessment is negative. It is not getting updated before being sent to the local authority, who is not coming out to evaluate the resident. The DON stated she would educate them on getting the PASRR fixed moving forward, especially if the residents are on mental illness medications. The DON stated, All residents get assessed for psych services, but moving forward they will make sure they take care of the PASRR correctly. The DON stated she wasn't sure what the risk to the resident was of a negative level one PASRR with evidence of a mental illness diagnosis, but noted, The purpose of PASRR is to get residents services if they have a diagnosis of mental illness. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility undated, policy titled PASRR Policy , revealed the facility staff will coordinate with the local Intellectual/Development Disability and/or Local Mental Health Authority to ensure a PASSAR level 2 evaluation is conducted when an individual's PASSAR level 1 screening indicated the individual may have an ID,DD, or MI.

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observation, 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 resident that meet professional standards of quality care for 2 (Residents #211 and #200) of 8 residents reviewed for baseline care plans. 1. The facility failed to include Resident #211's use of anti-coagulants (medications that prevent or slow down the formation of blood clots) in his baseline care plan. 2. The facility failed to include Resident # 200's preference to receive a Kosher diet in her baseline care plan. This failure could result in residents not receiving needed care and treatment. Findings Included: Record review of Resident #211's Admission Record dated 05/14/2025 revealed a [AGE] year-old resident with an admitted [DATE], with primary diagnoses which included: Heart Failure (condition where heart does not pump as well as it should) and Atrial Fibrillation (an irregular, often rapid heart rate that causes poor blood flow and increased risk for clots). Record review of Resident #211's Order Summary dated 05/14/2025 revealed medication orders which included: Apixaban [anticoagulant] Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for prevent blood clot (order date 05/05/2025) and Clopidogrel Bisulfate [anti-platelet] Tablet 75 MG Give 1 tablet by mouth one time a day for blood clot prevention. Record review of Resident #211's Baseline Care Plan initiated 05/05/2025 revealed the Care Plan did not include use of anti-platelet/anti-coagulant medication. During an interview with LVN-C on 05/16/2025 at 09:02 a.m., LVN-C stated she had only worked at the facility a couple of months and is the only MDS nurse right now, but they have a 2nd MDS Nurse position posted. She stated that baseline care plans are initiated by the DON and completed by the admitting nurse. LVN-C stated that anti-coagulants would not have been triggered by the baseline care plan assessment completed by the admitting nurse, so it would not have automatically be included in the baseline care plan. She stated she did not know if anti-coagulants should be included in the baseline care plan even if not triggered by the assessment, but did state they could have significant side effects such as bleeding which should be monitored. 2. Record review of Resident #200's Admission Record, dated 05/14/2025 revealed the resident was admitted on [DATE] with diagnoses which included: Fracture of unspecified part of neck of right femur (thigh) and irritable bowel syndrome (intestinal disorder causing pin, gas, diarrhea and constipation). (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #200's Order Summary dated 5/14/2025 revealed an order for REGULAR Diet REGULAR texture, THIN LIQUIDS consistency, no pork-kosher diet religious preference . The date of the order was 05/05/2025. Record review of Resident #200's baseline care plan initiated 05/03/2025 revealed an intervention for .no pork-kosher diet religious preference . but was not added to Care Plan until 05/05/2025, 5 days after her admission. During an interview with the DON, Clinical Resource Nurse and Administrator on 05/16/2025 at 09:15 a.m., the DON stated she opened the baseline care plans, but admitting nurses completed them and they were due within 48 hours of admission. The DON stated the baseline care plan should address potential health and safety concerns like falls and specialized diet orders, but she would have to look into whether the baseline care plan should include anticoagulants. Record review of the facility policy titled Comprehensive Person-Centered Care Planning revised 08/2017 revealed 1. Within 48 hours of the resident's admission, the facility will develop and implement a baseline care plan that includes instructions needed to provide effective and person-centered care. 2. The baseline care plan will include minimum health care information necessary to properly care for a resident including, but not limited to: .physician orders, dietary orders .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 33866 41651 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical and nursing needs to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 4 of 28 residents (Residents #24, #247, #91, and #84) reviewed for comprehensive care plans in that: 1. Resident #24's diagnoses of allergies and constipation were not included in her care plan. 2. Resident #247's care plan was not updated to reflect the removal of his foley catheter. 3. Resident #91's care plan, initiated 03/11/2025 was not updated to reflect an order dated 05/09/2025 for a WanderGuard (a wander management system designed to help prevent residents from wandering off and potentially getting lost or injured). 4. Resident #84 was admitted on [DATE] and readmitted on [DATE] with a nephrostomy tube (a thin, flexible tube inserted into the kidney to drain urine directly into a collection bag). The nephrostomy tube was not included in her care plan initiated 04/03/2025. These deficient practices could place residents at risk of not being provided with the necessary care or services and having personalized plans developed to address their specific needs. The findings were: 1. Record review of Resident #24's face sheet, dated 05/16/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses including Allergy Unspecified Subsequent Encounter and Constipation Unspecified. Record review of Resident #24's Quarterly MDS, dated [DATE], revealed a BIMS score of 02 which indicated severe cognitive impairment. Record review of Resident #24's care plan, revised 05/05/2025, revealed her diagnoses of allergies and constipation were not included in her care plan. 2. Record review of Resident #247's face sheet, dated 05/16/2025, revealed he was admitted to the facility on [DATE] with diagnoses including Encephalopathy and Cyst of Pancreas. Record review of Resident #247's Admission MDS, dated [DATE], revealed a staff assessment for mental status was performed and indicated both short- and long-term memory problems. Record review of Resident #247's care plan, initiated 04/22/2025, revealed [Resident #247] has Condom/Intermittent/Indwelling Suprapubic Catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 05/13/2025 at 9:32 a.m. revealed Resident #247 did not have an indwelling catheter. During an interview with MDS C on 05/15/2025 at 2:54 p.m., MDS C confirmed that Resident #247's indwelling catheter had been removed and that his care plan should have been updated to reflect the removal. 3. Record review of Resident #91's face sheet dated 05/14/2025 revealed an admitted [DATE] with diagnoses which included: metabolic encephalopathy (a brain disorder causing changes in brain function caused by metabolic disturbances such as illness or chemical imbalance) and alcoholic cirrhosis of liver without ascites (chronic liver damage without excess accumulation of fluid in abdomen). Record review of Resident#91's admission MDS assessment dated [DATE] revealed a BIMS score of 11 indicating moderate cognitive impairment and was assessed as not exhibiting wandering behavior. Record review of Resident #91's Physician Order Summary dated 05/14/2025 revealed an order for Monitor placement and functioning of WanderGuard to RIGHT wrist. Use (+) if in place and function correctly or (-) if not working and replaced every shift with Order date of 05/09/2025. Record review of Resident #91's elopement/wandering risk evaluation dated 05/09/2025 revealed a score of 16 indicating high risk. Record review of Resident #91's Care Plan initiated 03/11/2025 revealed use of a WanderGuard was not included in his Care Plan. Observation and interview with Resident #91 on 05/14/2025 at 11:20 a.m. revealed he was sitting at a dining table in the 2nd floor dining room waiting for lunch, although he resided on the 3rd floor. He was wearing a WanderGuard on his right wrist, but when asked about the WanderGuard, Resident #91 stated the nurse's put it there to make sure he took his medications. During an interview with the DON, Administrator and Clinical Resource Nurse on 05/15/2025 at 4:52 p.m. the DON stated Resident #91 was given on order for placement of the WanderGuard following increased observations of wandering behavior and a high risk score on his elopement/wander evaluation completed on 05/09/2025. The DON and Administrator both confirmed he had not actually ever eloped or exhibited exit-seeking behaviors, but wandered frequently and would not always be aware of where he was. The DON stated that the Care Plan should have been updated to include use of the WanderGuard and stated that it was just overlooked, stating they only have one MDS Nurse currently. The DON stated that not having the Wanderguard included in the Care Plan could affect coordination of care with not every staff having access to the same resident care information. 4. Record review of Resident #84's face sheet dated 05/16/2025 revealed she was admitted on [DATE] with re-admission on 04/16/2025, and with diagnoses which included: Displacement of Nephrostomy catheter, subsequent encounter, and metabolic encephalopathy (a brain disorder causing changes in brain function caused by metabolic disturbances such as illness or chemical imbalance). Record review of Resident#84's 5-day MDS assessment dated [DATE] revealed a BIMS score of 12 indicating moderate cognitive impairment, and was assessed as having an indwelling catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #84's Order Summary dated 05/16/2025 revealed orders which included: Monitor nephrostomy output every shift. The start date of the order was 04/17/2025. Record review of Resident #84's Care Plan initiated 04/03/2025 revealed placement/use of a Nephrostomy tube was not included in her Care Plan. Observation on 05/13/2025 at 10:55 a.m. revealed Resident #84 laying on her side on her bed, with a nephrostomy tube coming from her right flank and into a catheter bag filled with urine. During an interview with the DON and Clinical Resource Nurse on 05/16/2025 at 10:14 a.m., the DON stated that Resident #84 was admitted with a Nephrostomy tube, and that the Nephrostomy tube was not included in her Care Plan, but when asked if it should have been included in the Care Plan, the Clinical Resource Nurse stated they would have to look into it. Record review of the facility policy, Comprehensive Person-Centered Care Planning, revised August 2017, revealed, It is the policy of this facility that the interdisciplinary team shall develop a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment .4. Record review of the facility policy, Comprehensive Person-Centered Care Planning, revised August 2017, revealed, It is the policy of this facility that the interdisciplinary team shall develop a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131 Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications (excessive dose and duplicative therapy) for 1 of 6 residents (Resident #72) reviewed for unnecessary medicines, in that: The facility failed when in May 2025 Resident #72 received buspirone 5 mg twice a day for depression and Resident #72 received escitalopram 10 mg once a day for depression , reflecting a duplication of therapy when Psychotropic medications will not be given in excessive dosage. This failure could place residents at risk for adverse drug consequences and receiving unnecessary medications. The findings included : Record review of Resident #72's face sheet dated 5/14/25 reflected an [AGE] year-old resident who was admitted to the facility on [DATE] with diagnoses which included: Chronic Obstructive Pulmonary Disease (lung disease that damages the airways or other parts of the lungs, making it difficult to breathe), Heart Failure (condition in which the heart isn't pumping as well as it should) and Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) Record review of Resident #72's Quarterly MDS assessment, dated 2/26/25, reflected a BIMS score of 9, which indicated moderate cognitive impairment Record review of Resident #72 's comprehensive physician orders, dated 5/15/25, revealed orders for the following : - Buspirone 5 mg two times a day orally for depression. There was no documentation indicating the need for duplication of therapy. Further review revealed Resident #72 had been on the medication since 12/13/24. - Escitalopram 10 mg once a day orally for depression. There was no documentation indicating the need for duplication therapy. Further review revealed Resident #72 had been on medication since 12/13/24. Record review of Resident #72's comprehensive care plan, dated 12/16/24, revealed a care plan for Depression with interventions to administer medications as ordered. Record review of Resident #72's Medication Administration Record for May 2025 revealed the resident had received Buspirone 5 mg two times a day for depression and Escitalopram 10 mg once a day for depression. Record review of Resident #72's Pharmacy Consultant's Drug Regimen Reviews from 12/01/24 to 04/01/25 revealed no recommendation for Buspirone or Escitalopram, indicating an issue. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 05/16/2025 at 11:10 a.m., the DON stated she was unaware Resident #72 was on Buspirone 5 mg two times a day orally for depression and Escitalopram 10 mg once a day orally for depression. The DON stated these medications could be considered a duplication of therapy and could cause possible side effects when used concurrently. Record review of the facility policy dated 12/19, revised 12/23, revealed Psychotropic medications will not be in excessive dosage.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observations, interviews, and record reviews the facility failed to have drugs and biologicals used in the facility labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable; and the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls, for 1 of 2 medication rooms (Hall 200 medication room) and 1 of 6 medication carts (300 Hall Nurse cart) reviewed for safe medication storage. The facility failed when: 1. There were 2 expired medications for Resident #72 stored on the shelf in the Hall 200 medication room on 05/15/2025. 2. There was a sealed, unopened box of Semaglutide 4mg/3ml (a prescription medication used to Diabetes Type 2 and manage weight) for Resident #212, stored at room temperature inside the Hall 300 Nurse medication cart on 05/15/2025. There was a blue label marked Refrigerate on the outside of the box. 3. There was an opened bottle of Nasal Saline Spray on 05/15/2025 for Resident #247, marked with just the Resident's first initial and last name handwritten on the side of the bottle with a black Sharpie permanent marker, without any other identifying information. These failures could place residents at risk of receiving medications not having appropriate therapeutic effects. The findings included: 1. Record review of Resident #72's face sheet dated 05/16/2025 revealed an [AGE] year-old resident admitted [DATE] with diagnoses which included: Essential (primary) hypertension (high blood pressure). Record review of Resident #72's Quarterly MDS assessment dated ,d+[DATE]//2025 revealed a BIMS score of 9 indicating moderate cognitive impairment and was assessed as having hypertension. Record review of Resident #72's Physician Order Summary dated 05/16/2025 revealed an order for Lisinopril Oral Tablet 20mg (Lisinopril) Give 1 tablet by mouth two times a day for Hypertension . Observation on 05/15/2025 at 09:45 a.m. of the Hall 200 medication room with LVN -E, revealed a basket on a shelf in the medication room filled with 4 medications labeled for Resident #72, with 2 of these medications (Lisinopril 20mg) having expiration dates on 02/22/2025. (continued on next page)

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	675509	A. Building B. Wing	05/16/2025

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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN-E on 05/15/2025 at 9:50 a.m., LVN-E stated the two Lisinopril containers for Resident #72 expired in February and should not be used, but she did not believe Resident #72 was a current resident and did not know why these medications were still stored in the medication room. She did not know who was responsible for stocking the medication room and removing expired medications. During an interview on 05/15/2025 at 4:52 p.m. with the DON, Administrator and Clinic Resource Nurse, the DON stated Resident #72 was a Hospice patient still at the facility and she was admitted with those medications, but after her admission had been provided with new medications from their pharmacy. The DON stated she did not know why those medications were still being stored in the medication room, and stated the expired medications should have been removed and properly placed for disposal with the other expired medications. The DON stated that not removing and disposing of expired medications, it could result in expired medications being administered, and expired medications may not be as effective. Review of the facility policy titled Medication Access and Storage reviewed 05/2007 revealed Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction and re-ordered from the pharmacy is a current order exists. 2. Record review of Resident #212's face sheet dated 5/16/2025 revealed a [AGE] year-old resident admitted on [DATE] with diagnoses which included: Type2 Diabetes Mellitus with Diabetic Neuropathy (condition when body cannot use insulin correctly and sugar builds up in blood causing nerve damage). Record review of Resident #212's Physician Order Summary dated 05/16/2025 revealed an order for Semaglutide (1MG/DOSE) Subcutaneous Solution Pen-Injector 4MG/ML (Semaglutide) Inject 1 dose subcutaneously one time a day every Sun[Sunday] for weight loss. Observation on 05/15/2025 at 10:15 a.m. of the Hall 300 Nurse's medication cart with RN -F revealed a sealed, unopened box of Semaglutide 4mg/3ml for Resident #212, stored at room temperature inside the Hall 300 Nurse medication cart. There was a blue label marked Refrigerate on the outside of the box. During an interview with RN-F on 05/15/2025 at 10:15 a.m., RN-F stated that Resident #212 was a new admission and that the Semaglutide had been stored at room temperature inside of the medication cart, but since it was unopened, should have been stored in the refrigerator until opened. RN-F stated there was no way to know how long it had been stored at room temperature so should not be used. RN-F stated that the admitting Nurse or whoever was on duty when the Semaglutide arrived from the pharmacy should have ensured it was stored appropriately in the refrigerator. She stated that medications that have not been stored at the correct temperature may lose it effectiveness or even go bad. During an interview on 05/15/2025 at 4:52 p.m. with the DON, Administrator and Clinical Resource RN, the DON stated that the Semaglutide should have been stored in the refrigerator until opened for use, and that the Charge Nurse on duty when the medications arrived from pharmacy would have been responsible to ensure the medication was placed in the refrigerator for storage until opened. The DON stated medications may not be usable if not stored correctly. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Medication Access and Storage revised 05/2007 revealed It is the policy of this facility to store all drugs and biological in locked compartments under proper temperature controls and Medications requiring refrigeration .are kept in a refrigerator with a thermometer to allow temperature monitoring. 3. Record review of Resident #247's face sheet dated 05/16//2025 revealed a [AGE] year-old resident admitted on [DATE] with diagnoses which included Encephalopathy (a broad term for any brain disease that alters brain function or structure), and Chronic Obstructive Pulmonary Disease (COPD-a group of lung diseases that block airlfow and make it difficult to breathe.) Record review of Resident #247's Admission MDS, dated [DATE], revealed a staff assessment for mental status was performed and indicated both short- and long-term memory problems. Record review of Resident #247's Order Summary Report dated 05/16/2025 revealed an order for Saline Nasal Spray Nasal Solution (Saline) 1 spray in both nostrils every 24 hours as needed for congestion, with order start date of 04/25/2025. Observation on 05/15/2025 at 10:15 a.m. with RN-F of the Hall 300 Nurse's medication cart revealed an opened bottle of OTC saline nasal spray marked with Resident #247's first initial and last name handwritten on the side of the bottle with a black Sharpie permanent marker, without any other identifying information. During an interview with RN-F on 05/15/2025 at 10:15 a.m., RN-F stated that the bottle of saline nasal spray was not labeled correctly, having just a handwritten initial and last name on it, and noted that the name handwritten on the bottle matched Resident #247's first initial and last name and he was currently at the facility, but noted it was a very common name and there was no way to confirm that it was to be used for Resident #247 without proper labeling. RN-F stated that nasal sprays should be used for only one person and not shared as that could result in spread of infection. RN-F stated that the medication carts are used by staff on all 3 shifts and that she did not write on or administer that bottle of saline nasal spray. During an interview on 05/15/2025 at 4:52 p.m. with the Clinical Resource RN, DON, and Administrator, the Clinical Resource Nurse noted that if the nasal spray was an OTC medication it did not need to have the dosing and cautionary statements on a separate label, as that information would have been on that Resident's orders, and on the container itself, but she did agree that the bottle should have been labeled properly, not hand-written, with that Resident's full name and other appropriate identifying information to ensure the nasal spray was used only by the right resident.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27923 33866 Based on observations, interviews, and record reviews the facility failed to ensure each resident received, and the facility provided food prepared in a form designed to meet individual religious and cultural nutritional needs for 1 of 8 residents (Resident #200) reviewed for religious and cultural dietary needs. The facility failed to provide Resident #200 with a no pork Kosher diet (a diet which follows Jewish dietary laws, which has as a core principate that meat and dairy cannot be consumed together and only certain animals and birds are considered kosher) for the first 5 days after her admission on 04/30/2025. This deficient practice could place residents at risk for poor food intake, weight loss, and not having their religious nutritional preferences met. The findings included: Record review of Resident #200's Admission Record, dated 05/14/2025 revealed the resident was admitted on [DATE] with diagnoses which included: Fracture of unspecified part of neck of right femur (thigh) and irritable bowel syndrome (intestinal disorder causing pain, gas, diarrhea and constipation. Record review of Resident #200's Order Summary dated 5/14//2025 revealed an order for REGULAR Diet REGULAR texture, THIN LIQUIDS consistency, no pork-kosher diet religious preference . Date of order was 05/05/2025. Record review of Resident #200's Care Plan initiated 05/03/2025 shows an intervention for .no pork-kosher diet religious preference . initiated 05/05/2025. During an interview with Resident #200 on 05/13/2025 at 10:31a.m., Resident #200 stated she was Jewish and was upset that she was still receiving bacon and other pork products on her food trays even though she informed them when she was admitted that she can't eat pork and needs a Kosher diet. She stated that the last time she received bacon on her plate for breakfast, she complained to the CNA who brought her breakfast tray, so the CNA just removed the bacon from her plate. Resident #200 stated that did not solve the problem, as the juices from the bacon had touched her plate and her roll, and thus she could not eat the roll or anything on the plate. Observation of the lunch meal and tray card provided to Resident #200 on 05/14/2025 at 12:11 p.m. revealed she was provided a turkey sandwich, sweet potatoes and applesauce for lunch - no pork. The menu for that day included sliced pork with gravy. Her tray card did not say Kosher diet, but listed pork as a dislike. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on with Resident #20 on 05/14/2025 at 12:15 p.m. revealed Resident #200 stated the dietary manager visited her that morning and reviewed her meal preferences and appropriate substitutes. She told him no pork, and she stated he seemed unaware of other parts of Kosher diet when they discussed substitutes, such as not mixing meats with milk (or milk products like cheese) Resident #200 also stated that when pork was taken away, the facility seemed unable to provide her other suitable sources of protein she liked such as cottage cheese and yogurt, which she stated the Dietary Manager did provide to her after he met with her this morning. Resident #200 stated she was happy that today for lunch she was provided a Kosher diet with appropriate substitutes for pork, but stated it should not have taken 5 days after she was admitted to finally receive the correct diet. Interview on 05/15/2025 at 3:21 p.m. with the Dietary Supervisor revealed that he or the admission coordinator try to meet with all new admissions within 48 hours of their admission for food preferences, and he obtains diet slips from the Nurse's regarding dietary orders. He stated he did not know why Resident #200 kept receiving pork products even though it was listed as a dislike on her tray card, other than he checks all trays leaving the kitchen, but notes on some days like the day before when he had 3 staff call-in, he is not always able to check all the meal trays before they leave the kitchen. The Dietary Supervisor stated he does not have a thorough knowledge of Kosher diets, and stated Resident #200 has been the first resident since he has worked at facility to request a Kosher diet, and he was going to research and learn more about Kosher diets to meet the special needs of residents on this diet. He stated it was not acceptable that Resident #200 did not receive a Kosher diet for the first 5 days after she was admitted , because it was matter of respect to honor her religious beliefs about food. He stated that the facility did not have a policy regarding the provision of specialized diets. Interview on 05/15/2025 at 05:19 p.m. with the DON, Administrator and Clinical Resource Nurse revealed that the process for new admissions was for original diet orders to come from documents and verbal report from the transferring hospital or facility or from the family, and then diet orders are updated following physician and dietician assessments. The DON stated it was important for Residents to receive the correct diet and texture and to have their religious dietary preferences honored. Telephone interview on 05/16/2025 at 5:19 p.m. with the Dietician revealed that she was able to meet with Resident #200 this week, and obtained all her information on diet and food preferences. She stated that the facility does not get many requests for Kosher diets, so most of the staff would be unfamiliar with this diet. The Dietician stated she has information regarding Kosher diets that she has provided to the Dietary Supervisor, and stated no one called her after Resident #200's admission to obtain more specific information on Kosher diets. The Dietician stated that not providing the diet that follows a Resident's religious and cultural beliefs could result in the Resident not eating, weight loss and feeling disrespected.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 27923 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 facility in that: 1. The facility failed to maintain a garbage bin under the hand sink to collect dirty hand towels after use. 2. The facility failed to date a package of cheese and two 5 lb containers of cottage cheese in the refrigerator. 3. The facility failed to date a container of 7 ounces of dried rice in the dry storage room. 4. The facility failed to replace to overhead light bulbs in the dish machine room 5. The facility failed to cover two sections of floor baseboard in the main kitchen area that had an uncovered paint surface. 6. The facility failed to secure a ceiling tile in the main kitchen that showed exposed insulation underneath the tile. These failures could place residents at risk for food borne illness. The findings included: Observation on 05/013/2025 from 9:15am until 9:50am with the Food Service Director at revealed the following: a. There was not a garbage can underneath the hand sink and after using the sink, the Food Service Director was observed carrying the dirty hand towel to a garbage bin in another section of the kitchen. b. In the refrigerator there were two 5 lb containers of cottage cheese that were undated. c. In the dry storage room there was a plastic container of 7 ounces of dried rice that was undated. d. In the dish machine room there were two florescent light bulbs in an overhead set of three light bulbs that were not working. e. In the main kitchen area there were two sections of floor baseboard measuring approximately 1 foot in length that were uncovered showing an exposed open surface that could collect dust. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. In the main kitchen area there was a 2x2 foot ceiling tile that was not secured to the ceiling and showed exposed insulation underneath the tile. During an interview on 05/03/25 at 9:55am, the Food Service Director stated that all Dietary staff are responsible for ensuring that food items in the refrigerator and dry storage rooms are dated to ensure that food does not expire past the use date. The Food Service Director stated that overhead lights in the dish machine room needed to be working properly to ensure employee safety. The Food Service Director stated that an exposed floor baseboard would not ensure proper kitchen sanitation. The Food Service Director stated that an exposed ceiling tile that could allow insulation to fall on the kitchen floor would not ensure kitchen infection control. During an interview with the Administrator on 5/14/25 at 9:30am he stated that food items must be dated for safe consumption, that overhead lighting must be working for employee safety, that floor baseboards must be covered for kitchen sanitation, and that an exposed ceiling tile with insulation could create an infection control concern. Record review of facility policy Sanitation in Dietary dated 10/2007 stated that All kitchens, kitchen areas, and dining areas shall be kept clean, free from liter and rubbish and protected from rodents, roaches, flies, and other insects. Record review of facility policy Infection Control Policy/Procedure for Dietary Services dated 05/2007 stated that the Director of Food Service is responsible providing for the proper receipt and storage of all food supplies. Record review of facility policy, Frozen and Refrigerated Storage revised 12/05/2017 revealed, Policy: PHF/TCS (Potentially hazardous/Time temperature control for safety) foods will be properly refrigerated or frozen to reduce the potential for food borne illness and maintain product integrity. 7. Proper labeling of cooked foods includes the date placed in the refrigerator, and an expiration or 'use by' date. Refrigerated products that are opened must be labeled with an 'opened on' date. The 'use by' date is 7 days from when the product was opened, unless there is a manufacturer's use by, expiration or sell by date. 13. On a daily basis the Cooks will: b. Check labeling and dating, use any items that are close to their use by date and discard any items that are past their use by date. Record review of facility policy, Dry Food Supplies Storage revised 11/15/2017 revealed, 9. All opened products must be resealed effectively and properly labeled, dated and rotated for use. This may require storage in an approved NSF container or food grade storage bag. 11. Canned goods that have a compromised seal will be removed from service and stored in a separate area, until they are picked up by the distributor of discarded. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed: 3-305.11, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41651 Based on interview and record review, the facility failed to maintain medical records that were complete and accurately documented for 3 (Resident #10, Resident #24, and Resident #28) of 33 residents reviewed for medical records, in that: 1. Resident #10's clinical record included Nurse Practitioner notes which referred to another resident. 2. Resident #24's diagnosis of Osteoporosis was not included in her diagnoses list. 3. Resident #28's diagnosis of Depression was not included in her diagnoses list. These failures could result in inadequate care due to incomplete and inaccurate medical records. The findings were: 1. Record review of Resident #10's face sheet, dated 05/16/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses including Anemia and Hypertension. Record review of Resident #10's progress notes as of 05/15/2025 revealed the Nurse Practitioner entered visit notes dated 03/11/2025, 01/26/2025, and 12/29/2024 which referred to another resident. 2. Record review of Resident #24's face sheet, dated 05/16/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses including Gastronomy Status and Dysphagia Following Cerebral Infarction. Record review of Resident #24's Quarterly MDS, dated [DATE], revealed a BIMS score of 02 which indicated severe cognitive impairment. Record review of Resident #24's care plan, revised 07/03/2024, revealed, [Resident #24] has Osteoporosis and is at risk for spontaneous fracture. Record review of Resident #24's orders revealed, Alendronate Sodium Oral Tablet 70 MG (Alendronate Sodium) Give 1 tablet by mouth in the morning every 7 day(s) for osteoporosis give it every MONDAY. Further review of Resident #24's face sheet revealed her diagnoses of Osteoporosis was not listed. Record review of Resident #24's clinical record as of 05/16/2025, revealed her diagnosis of Osteoporosis was not reflected in her list of diagnoses. 3. Record review of Resident #28's face sheet, dated 05/16/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses including End Stage Renal Disease and Dependence on Renal Dialysis. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #28's Quarterly MDS, dated [DATE], revealed a BIMS score of 14 which indicated intact cognition. Record review of Resident #28's care plan, revised 05/23/2024, revealed [Resident #28] at risk for depression [related to] Disease Process. Record review of Resident #28's progress notes revealed a note dated 12/02/2024, MD ordered [anti-depressant] .for anxiety related to depression. [Responsible Party] and Resident aware of [diagnosis] and consented. Further review of Resident #28's face sheet revealed her diagnoses of Depression was not listed. Record review of Resident #28's clinical record as of 05/16/2025, revealed her diagnosis of Depression was not reflected in her list of diagnoses. During an interview with the DON on 05/16/2025 at 12:16 p.m., the DON confirmed the findings outlined above and stated that she expected staff to maintain resident clinical records completely and accurately. The DON stated that all diagnoses should be listed on the resident face sheet because the face sheet is sent with the resident when they visit outside medical providers and/or when they are sent to the hospital. The DON stated it is important for outside providers to be aware of all the residents' diagnoses. Record review of the facility policy, Medical Record, Content of, revised August 2007, revealed, It is the policy of this facility that a separate medical record shall be maintained for each resident .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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observation, interviews, and record reviews, the facility failed to 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 disease and infection for 1 of 7 residents (Resident #9) reviewed for infection control, in that: The facility failed to ensure CNA-H consistently sanitized her hands in between glove changes while providing wound care for Resident #9 on 05/15/2025, This deficient practice could place residents at-risk for infection due to improper care practices. These findings included: Record review of Resident #9's face sheet, dated 5/14/2025, revealed an admitted [DATE] with re-admit on 02/17/2025, with diagnoses which included: Sequelae of cerebral infarction; Type 2 Diabetes Mellitus; and Edema Record review of Resident #9's MDS Quarterly assessment, dated 04/02/2025 revealed the resident had a BIMS score of 15, indicating normal cognition. Resident #9 was assessed as having one stage 3 pressure ulcer (full-thickness skin loss where subcutaenous fat may be visible, but bone or muscle not exposed) and one stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle) and one unstageable pressure ulcer (pressure ulcer known but not able to be staged due to coverage of wound bed by dead tissue). Record review of Resident #9's care plan revealed focus areas which included: has actual impairment to skin integrity r/t abscess to left lower shin (initiated 12/20/2024); has wound of the left medical calf r/t vascular ulceration (initiated 03/25/2025) with interventions for wound local to evaluate and treat; has venous ulcer of the left ankle .and has diabetic ulcer of the right plantar [thick tissue that connects heel bone to toes] (initiated 4/14/2025). Record review of Resident #9's Order Summary dated 05/14/2025 included an order to Cleanse left ischium [lower back part of hip] with [wound cleansing solution] gently pat dry with gauze, apply skin prep to periwound [area surrounding wound], apply [ointment that cleanses and removes dead tissue] cover with calcium alginate [key ingredient in wound dressing] and secure with dry dressing daily, one time a day for Stage IV . Observation on 05/15/2025 at 02:47 p.m. of wound care treatment to Resident #9 by LVN-H revealed LVN-H changed gloves multiple times while providing care including after moving from dirty to clean areas and after touching outside environmental objects such as the bedside table, and trash can, but did not sanitize her hands in between each glove change. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN-H on 05/15/2025 at 3:10 p.m. LVN-H stated she had only been working as treatment nurse for a couple of weeks, and stated she did not sanitize her hands after each glove change while providing wound care to Resident #9, because she forgot, but also stated she should have. She stated not sanitizing her hands in between glove changes could result in spread of infection as the hands could be contaminated during process of changing gloves. During an interview with the DON on 05/15/2025 at 5:10 p.m., the DON stated the Nurse should have sanitized her hands in between each glove change. She stated no doing so could result in spread of germs. The DON stated LVN-H has received training in infection control, hand hygiene and wound care. Record review of the facility's Skills Checklist-Treatment dated 05/13/2025 revealed LVN-H demonstrated competency in handwashing and wound treatment. Review of facility policy, titled Hand Hygiene revised 12/2023 revealed Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: Before donning [putting on] sterile gloves after removing gloves .

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	05/16/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on observation, interview and record review the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 8 wheelchairs reviewed for essential equipment. The facility failed to ensure Resident #198's wheelchair brakes were functioning correctly on 05/13/2025. These failures could place residents at risk of not having functional and safe mode of mobility. Findings include: Record review of Resident #198's Admission Record dated 05/16/2025 revealed a [AGE] year-old resident admitted on [DATE] with diagnoses which included: Fracture of part of neck of unspecified femur (break in part of thigh bone that connects to hip joint); repeated falls; and unsteadiness on feet. Record review of Resident #198's Admission MDS assessment dated [DATE] revealed a BIMS score of 14, indicating normal cognition. She was assessed as using a wheelchair for mobility and needing partial/moderate assistance for bed to chair transfers. Record review of Resident #198's Care Plan revealed a focus area for ADL Self Care Performance Deficit r/t weakness with interventions that included staff assistance for wheelchair transfers. During an interview with Resident #198 on 05/13/2025 at 12:36 p.m., Resident #198 stated that she was at facility for rehabilitation following a hip replacement, and was happy with the therapy she was receiving, but had a concern about the brake on the loaner wheelchair the facility provided to her to use. She stated the right brake on the wheelchair was broken, would not close down sufficiently to stop movement in that tire, so it would move a little on the right side when she was transferred into and out of the wheelchair. Resident #198 stated she informed the therapist the day before (05/12/2025), and the therapist stated she would call to get the wheelchair fixed. Observation on 05/13/2025 at 12:40 p.m. of Resident #198's loaner wheelchair. The right-side brake did not engage completely, providing some, but not complete braking function to keep the tires from moving. During an interview with PT-I on 05/14/2025 at 2:57 p.m., PT-I stated that Resident #198 had her own wheelchair at home, but the wheelchair she was currently using at the facility was a loaner from the facility. She stated that Resident #198 cannot self-transfer, and requires one-person assist for transfers with some weight bearing restrictions. PT-I stated one of the therapists told her about the wheelchair first thing this morning, and she had arranged for their maintenance person to fix the brake, and in the meantime the DOR had requested another replacement loaner wheelchair from one of their sister facilities that was just delivered. PT-I stated that not having both brakes on her wheelchair in good functioning order could increase the risk for falls, especially during transfers. (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	05/16/2025

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Parklane West Healthcare Center	2 Towers Park LN San Antonio, TX 78209

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with COTA-J on 05/14/2025 at 03:02 p.m., COTA-J stated that Resident #198 had told her about the loose wheelchair brake late yesterday afternoon, and she tried to tighten it herself, but did not have the right tools, so informed the DOR this morning. COTA-J stated that she had not noticed the right brake to be loose on the wheelchair when she worked with Resident #198 during previous therapy. Interview on 05/14/2025 at 3:50 p.m. with the DOR, revealed the DOR was in the gym, assisting maintenance to fix the brake on the loaner wheelchair. The DOR stated that they follow the same procedures for broken equipment as the rest of the facility and that was to submit a work order with their maintenance department in TELS, and if it required more specialized intervention could send for repairs with manufacturer or specialty companies as needed. The DOR stated she immediately contacted maintenance when she was told of the loose brake on Resident #198's wheelchair and made arrangements to borrow another wheelchair from one of their nearby sister facilities. The DOR stated they do not have a specific policy regarding wheelchair maintenance, but would refer to the facility maintenance policy. During an interview with the Administrator and DON on 05/15/2025 at 5:25 p.m., the Administrator stated their maintenance department could do repairs on wheelchairs, and although they currently do not have a maintenance supervisor, their regional and sister facility maintenance supervisors were covering maintenance needs. Record review of the facility's policy entitled Equipment Inspection and Maintenance dated 07/2018 revealed It is the policy of this community to maintain all equipment provided by the facility, in good working order to ensure the safety and wellbeing of all residents and staff.

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	675509	A. Building B. Wing	05/16/2025

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 33866 41651 Based on observation, interview, and record review, the facility failed to provide a resident environment that was free of pests for 1 of 1 facility reviewed for effective pest control in that: The facility failed to provide a resident environment that was free of pests as live roaches were observed in Resident #9's bathroom and in the facility conference room This deficient practice could result in illness and/or psychosocial harm for residents living in areas with insects. The findings included: Observation on 05/13/2025 at 11:15 a.m. in Resident #9's bathroom, revealed a live roach crawling on the bathroom wall near a vent in the wall. Observation on 05/13/2025 at 3:40 p.m. revealed a live roach crawling on the surveyor's bag in the facility's first-floor conference room. During an interview with Resident #9 on 05/13/2025 at 11:15 a.m., Resident #9 stated that he had seen roaches coming out of the vents in his shower room and had one crawl on him in bed 2 nights prior. He stated that he has seen the pest control company come out to spray in his room, but did not feel it was effective. During an interview with HSK G on 05/13/2025 at 11:23 a.m., she stated she had worked as a housekeeper at the facility for 2 months and while cleaning has observed roaches under beds, in the breakroom, laundry room and has seen their droppings in some of the bathrooms. She stated she usually sees them when she first walks into a room and turns on the light. Interview with the Administrator on 05/13/2025 at 3:45 p.m. revealed that he has received reports of roaches in the facility, most of those reports coming from residents living on the second floor, and that the facility has a contract with a pest control company which were scheduled to come out to exterminate today. The Administrator stated the pest control company comes out regularly to treat for pests, and compared to other places he has been, he does not feel the pest problem at this facility was a big, big problem. Record review of the facility policy, Maintain Effective Pest Control Program, undated, revealed, Policy: Maintain and effective pest control program so that the facility is free of pests and rodents.