STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676281	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westover Hills Rehabilitation and Healthcare	9922 State Hwy. 151 San Antonio, TX 78251

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46131 Based on interview and record review, the facility failed to provide pharmacological services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 10 residents (Resident #1 and Resident #2) reviewed for pharmacy services. 1. LVN A administered Cefazolin (Antibiotic) 6 GM in 250 ML instead of Cefazolin 6 GM in 1000 ML to Resident # 1. The non-compliance was identified as past non-compliance. The noncompliance began on 06/11/2024 and ended on 06/12/24. The facility had corrected the non-compliance before the survey began. 2. The facility failed to ensure that controlled medications were secured. The non-compliance was identified as past non-compliance. The noncompliance began on 7/17/2024 and ended on 7/18/24. The facility had corrected the non-compliance before the survey began. These deficient practices could affect all residents who receive medication from the facility and place them at risk for adverse reactions, decline in physical health. Findings were : 1. Record review of Resident #1's face sheet, dated 02/11/25, revealed an initial admitted [DATE]. Resident #1 had diagnoses that included: Post Traumatic Stress Disorder (a mental health condition that some people develop after they experience or witness a traumatic event), Depression. (persistent symptoms of sadness, and a loss of interest in daily activities) and Prosthetic joint infection (defined as infection involving the joint prosthesis and adjacent tissue). Record review of Resident #1's Admission MDS assessment, dated 6/11/24, revealed a BIMS score of 15, which indicated intact cognition. Record review of Resident #1's Care plan, initiated on 06/11/2024 and revised on 7/28/2024, revealed a focus of: [residents name] is on antibiotic therapy related to orthopedic device, receiving Cefazolin via PICC line. Interventions: Administer medication Cefazolin as ordered. (continued on next page)

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
	676281	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westover Hills Rehabilitation and Healthcare	9922 State Hwy. 151 San Antonio, TX 78251

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's physician orders, dated 06/07/2024, revealed medication Cefazolin Sodium Injection Solution Reconstructed 3 GM (Cefazolin Sodium) use 6 grams intravenously every shift for infection related to Orthopedic Device. Record review of Resident #1's electronic medication administration record for 6/11/24 revealed that Cefazolin 6 GM in 1000 ML was administered by LVN A at 8 PM via PICC. Interview with LVN A on 2/11/25 at 10:55 A.M. revealed that on 6/11/24 after she administered the IV medication to Resident #1, she realized after the IV infusion, the empty IV bag read Cefazolin 6 GM in 250 ML, not Cefazolin 6 GM in 1000 ML. LVN A called DON, who instructed her to call the facility nurse practitioner and pharmacy. LVN A stated she thought she was giving the correct dose, but by not double-checking the IV bag with the medication administration record, a medication error occurred, which could have harmed the resident. Interview with the Pharmacy consultant on 2/11/25 at 1:20 P.M. revealed that this error occurred as a pharmacy oversight, sending incorrect concentration. The pharmacist consultant stated No harm to Resident # 1 occurred as medication was simply given in less normal saline, which was nonirritant to veins as it was administered via a PICC line. Interview with the facility nurse practitioner on 2/11/25 at 2:20 PM revealed he was not concerned with the medication error as the IV antibiotic was administered with less normal saline, and no adverse effects occurred to Resident # 1 because LVN A recognized the error quickly and had it corrected. Interview with DON on 2/11/25 at 3:15 P.M. revealed that on 6/11/24, at approximately 830 PM, she was notified by LVN A that an IV medication error had occurred. DON stated that she expected all licensed nurses to follow policy and procedure regarding medication administration, as failure to do so could negatively impact residents. She currently has her ADON's review all new admission orders and medication delivered by the pharmacy to ensure the correct medication has been delivered and she audits this at random. Prior to survey entrance, the facility provided Inservice to 100 % of Nursing staff on 6/11/24 - 6/12/24 regarding the Following 5 medication rights: 1. right Patient 2. right person 3. right time 4. Right route 5. right dose. During staff interviews on 2/12/2024 at 8:45 a.m -10 AM., with (LVN B), (LVN C) , (LVN D) , (LVN E) , (LVN F), (LVN G) and (RN H), (RN I), (RN J) from all shifts staff stated they had been in-serviced on following the 5 rights to medication administration. Observation on 2/12/25 at 10:33 a.m. revealed DON randomly checked new admission orders, ensuring the five medication rights. Record review of facility policy Medication Administration, IV Medication, dated 8/2020, revealed compare label with a physician order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676281	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westover Hills Rehabilitation and Healthcare	9922 State Hwy. 151 San Antonio, TX 78251

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2 Record review of resident # 2's face sheet dated 2/13/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included: Dysphagia (difficulty swallowing foods or liquids), Renal Dialysis (a procedure that filters excess fluid and waste and Coronary Angioplasty Status (A procedure that opens the blocked artery). Record review of Resident # 2's Admission MDS assessment dated [DATE] reflected a BIMS score of 15, which indicated that cognition was intact. Record review of Resident's # 2's monthly physician orders for June 2024 revealed an order for Ativan 1 MG, administer one tablet by mouth every 24 hours as needed for anxiety for 14 days. Record review of Resident # 2's progress noted dated 6/27/24 revealed that Resident # 2 was transported to the hospital due to a change of condition and did not return. Record review of Resident # 2's narcotic sheet for Ativan 1 mg reflected 24 Ativan were received on 6/20/24 and 14 Ativan were present on 6/26/24. Record review of Resident # 2's narcotic sheet for Ativan 1 mg revealed nurses were signing after each shift verifying medication Ativan 1 mg quantity 14, was present from 6/26/24 - 7/17/24 . Interview with the DON on 2/13/25 at 10:34 A.M., revealed on 7/17/24 , she was conducting monthly drug destruction when she discovered the narcotic sheet for Ativan 1 MG for Resident # 2 was present, but the blister pack was missing. Interview on 2/13/25 at 11:00 A.M., the DON stated that this medication-drug discrepancy occurred because of outdated controlled drug counting practices. During drug counts on each shift, nurses only counted the amount of medication in a blister pack and did not read the resident's name to include the name of the medication and the amount left. The DON stated on 6/17/24 -6/18/24, in-service was conducted moving forward, all as-needed narcotic medication required two licensed nurses' signatures, and the narcotic drug counting practice was updated. Prior to the survey entrance, the facility in-serviced 100 % all nursing staff on 6/17/24 - 6/18/24 on the updated narcotic medication counting process and all as-needed medication requiring two licensed nurses' signatures. During staff interviews on 2/13/2024 at 6:45 a.m 8:00 AM., with (LVN B), (LVN C) , (LVN D), (LVN E) , (LVN F), (LVN G) and (RN H), (RN I), (RN J) from all shifts staff stated they had been in-serviced on following narcotic medication counting process and as-needed narcotic medication requiring two licensed nurses' signatures Observation on 2/14/25 at 6:33 a.m., revealed LVN B and RN H counting narcotics at shift change updated narcotic medication counting process. Observation on 2/14/25 at 9:05 a.m., revealed LVN G and LVN E signing for an as-needed narcotic medication. Record review of the facility policy Controlled Medications, December 2019, reflected Any discrepancy in controlled substance medication counts is reported to the DON immediately.