

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676281	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Westover Hills Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 4 residents (Resident #1) whose assessments were reviewed, in that: Resident #1's wandering assessment and MDS did not reflect he had wandering behaviors. This failure could place residents at risk for inadequate care due to inaccurate assessments. The findings were: Record review of Resident #1's face sheet, dated 8/21/25, revealed an admission date of 3/7/25 with diagnoses including: cerebral infarction (when blood flow to a part of the brain is obstructed typically by a blood clot causing death to the brain cells), disorder of visual pathways in (due to) vascular disorders left side (the visual pathway consist of structures that carry visual information from the retina to the brain. Lesions in that pathway cause a variety of visual field defects), other abnormality of gait and mobility, and cognitive communication deficit. Record review of Resident #1's care plan, updated 8/20/25, revealed the resident would wander related to impaired safety awareness, unintentionally intrudes on the privacy of others or activity related to impaired cognition. An intervention to redirect resident from wandering by reorienting Resident #1 and direct/assist to his room was also added on 8/20/25. Record review of Resident #1's Quarterly MDS, dated [DATE], revealed a BIMS score of 10, indicating moderate cognitive impairment. Section E Behavior revealed he had no wandering behaviors. Record review of Resident #1's nursing progress notes, dated 8/21/25, revealed: -3/10/25 at 9:24 a.m. Resident wandering the hall, looking for his room. He is A/O x2 currently and does not remember why he is here. Easily redirected and compliant with directions. [NP] updated about patient status. Will continue to monitor. Written by RN A-8/5/25 12:07 a.m. Resident was up and walking around and going into other resident's rooms. Resident was redirected and got angry at staff, also attempted to walk to the front door, but redirected to go back to his room. Resident was screaming down the hallway not wanting to go to his room. Staff encouraged resident to stay in bed during the night and use his wheelchair while his OOB. Staff attempted to take resident back to his room and but refused, resident is sitting by the nurse's station being observed. Written by LVN B Record review of Resident #1's Elopement and Wandering Evaluation assessment, dated 6/10/25, revealed answers to question revealed he had no history of or current behavior of wandering and he was a low risk. Record review of Resident #1's assessment on 8/21/25, revealed two wandering assessment were completed in the past. One was completed on 3/7/25 with low risk and another on 6/10/25 with low risk. No other wandering/elopement assessment were found. During an interview on 8/20/25 at 1:44 p.m. RN A stated Resident #1 was known to go into other residents' room. RN A stated when other residents would complain about the resident being in their rooms she would go check and he would be taking products like toilet paper he already had in his room. RN A stated she would redirect him to retrieve the items from his room. During an interview on 8/21/25 at 10:35 a.m. interview with Resident #2 who's room was across the hall from Resident #1 stated once Resident #1 had come in her room. She stated she was coloring and facing her window when Resident #1 tapped her on the shoulder and stated something in Spanish as he pointed out the window. Resident #2 stated she told him to leave her room, and he did. During an interview on 8/21/25 at 11:47 a.m. MDS C stated she was informed on 8/20/25 that Resident #1 had behaviors of looking for a family member and would require staff to reorient him. MDS C stated they would normally run a 24 hours report in the morning and filter for key words to find any resident with changes in condition. MDS C stated the ADONs also assist with looking over the 24 hour reports and updating any assessments or care plans. MDS C stated she had recently been out for personal reasons and was not aware the resident had a change in condition. MDS C stated by not updating changes in the resident's care plan staff would not be aware of how to treat the resident. The MDS C stated staff used the care plan to be aware of resident behaviors and would also prompt care areas in the point of care nursing aides used. During an interview on 8/21/25 at 12:09 p.m. ADON D they would run a 24-hour report and read the report to see if any residents had a change in condition. ADON D stated there were 3 ADONs who would split up the reports according to hallways. ADON D stated however 1 of the ADONs had recently started and another ADON had been out of FMLA. The ADON stated the DON was also helping her read the 24-hour reports daily. ADON D stated she was not aware of the nursing progress note from 8/5/25 where the resident was exhibiting exit seeking and wandering behaviors. ADON D stated had she seen that note she would have spoken to the resident to see what was going on, spoken to the nursing staff, and made the DON aware. ADON D stated they would also notify the doctor and see if they needed to update any orders. ADON</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments to reflect the current condition for 1 of 4 residents (Resident #1) reviewed for care plan revisions. The facility failed to ensure Resident #1's care plan was comprehensive and updated to reflect Resident #1 had wandering and exit seeking behaviors. This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs. The findings included: Record review of Resident #1's face sheet, dated 8/21/25, revealed an admission date of 3/7/25 with diagnoses including: cerebral infarction (when blood flow to a part of the brain is obstructed typically by a blood clot causing death to the brain cells), disorder of visual pathways in (due to) vascular disorders left side (the visual pathway consist of structures that carry visual information from the retina to the brain. Lesions in that pathway cause a variety of visual field defects), other abnormality of gait and mobility, and cognitive communication deficit. Record review of Resident #1's care plan, updated 8/20/25, revealed the resident would wander related to impaired safety awareness, unintentionally intrudes on the privacy of others or activity related to impaired cognition. An intervention to redirect resident from wandering by reorienting Resident #1 and direct/assist to his room was also added on 8/20/25. 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