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	05/23/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 3 residents (Resident #1) reviewed for reporting allegations of ANE. The facility failed to report an allegation of ANE when Resident #1's family member alleged Resident #1 was neglected and caused a skin ulcer. This failure could place residents at risk of being neglected.The findings include:A record review of Resident #1's admission record, dated 5/23/2026, revealed an admission date of 5/10/2026 and a discharge date of 5/18/2026. Resident #1 had diagnoses which included laceration of the left knee (a wound to the knee), urinary tract infection (an infection of the bladder), and personal history of other infectious and diseases 9bladder infections, lung infections). A record review of Resident #1's admission MDS assessment, dated 5/10/2026, revealed Resident #1 was a [AGE] year-old female who was admitted to the facility for rehabilitation for a post hospitalization with a left knee wound. A record review of Resident #1's care plan, dated 5/23/2026, revealed Resident #1 was dependent on staff assistance for all ADLs. A record review of Resident #1'a skin assessment, dated 5/11/2026, revealed LVN C assessed Resident #1 was admitted with skin breakdown to her right big toe and left knee surgical wound. A record review of Resident #1's Nursing Progress note revealed Resident #1 was administered an enema on the evening of 5/17/2026 at 8:00 PM by LVN A and LVN B. A record review of Resident #1's Nursing Progress note revealed Resident #1 was discharged to the hospital on 5/18/2026 related to lethargy. During an interview on 5/23/2026 at 2:54 PM Resident #1's family member stated Resident #1 was admitted to the facility after surgery to her leg and hospitalization. Resident #1's family member stated Resident #1 was discharged from the hospital and admitted to the nursing home and lived there for maybe a week. Resident #1's family member stated he and Resident #1's family visited often and had observed no one would assist Resident #1 with reposition or provide incontinent care, and many times the family would intervene and insist the staff provide care. Resident #1's family member stated he learned on 5/18/2026 that Resident #1 was sent to the hospital for an infection. Resident #1's family member stated he was given a report on 5/21/2026, by the hospital nurses that Resident #1 had an ulcer to her backside / buttocks and neck areas and may have contributed to her diagnosis of systemic infection (an infection throughout the body). Resident #1's family member stated he grew upset and recalled there were days when he and Resident #1's family visited Resident #1, and no one provided care. Resident #1's family member stated he called the nursing home to complain. Resident #1's family member stated he reached the DON and she heard his complain but he felt she was defensive and indifferent. During an interview on 5/23/2026 at 11:40 (continued on next page)

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

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM, the DON stated Resident #1 was admitted to the facility on [DATE] for LTC rehabilitation with ADL supports complicated by a left knee surgery after a fall she had at home. The DON stated Resident #1 was assessed with a change of condition on the morning of 5/18/2026 by the NP. The facility supported the NP's orders for Resident #1 to be sent to the hospital for evaluation and treatment. The DON stated she received a phone call from Resident #1's Representative on or about 5/21/2026, who was upset that Resident #1 had pressure ulcers to her back / buttocks. The DON stated she discussed the complaint with the Administrator, and they concluded the allegation was without merit as the interviews and record reviews revealed LVN A and LVN B had administered an enema on the evening of 5/17/2026 and neither nurse observed any skin breakdown. The DON stated the facility would report allegations of ANE with injury within 2 hours and without injury within 24 hrs. The DON stated the Administrator and herself decided the allegation did not rise to the level of a self-report to the state agency since the allegation had no evidence. A record review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, dated April 2001, revealed Presidents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. policy interpretation and implementation: . Identify and investigate all possible incidents of abuse, neglect, mistreatment, poor misappropriation of resident property. Investigate and report any allegations within time frames required by federal requirements.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility had evidence that all alleged violations were thoroughly investigated for 1 of 3 residents (Resident #1) reviewed for investigation of alleged ANE. The facility failed to investigate an allegation of ANE when Resident #1's family member alleged Resident #1 was neglected and caused a skin ulcer. This failure could place residents at risk of being neglected.The findings include: A record review of Resident #1's admission record dated 5/23/2026 revealed an admission date of 5/10/2026 and a discharge date of 5/18/2026 with diagnoses which included laceration . left knee (wound to knee), urinary tract infection (bladder infection), and personal history of other infectious . diseases (bladder infections, lung infections). A record review of Resident #1's admission MDS assessment dated [DATE] revealed Resident #1 was a [AGE] year-old female admitted for rehabilitation for a post hospitalization with a left knee wound. A record review of Resident #1's care plan dated 5/23/2026 revealed Resident #1 was dependent on staff assistance for all ADLs. A record review of Resident #1'a skin assessment dated [DATE] revealed LVN C assessed Resident #1 was admitted with skin breakdown to her right big toe and left knee surgical wound. A record review of Resident #1's Nursing Progress noted revealed Resident #1 was administered an enema on the evening of 5/17/2026 at 8:00 PM by LVN A and LVN B. A record review of Resident #1's Nursing Progress noted revealed Resident #1 was discharged to the hospital on 5/18/2026 related to lethargy. During an interview on 5/23/2026 at 2:54 PM Resident #1's family member stated Resident #1 was admitted to the facility after surgery to her leg and hospitalization. Resident #1's family member stated Resident #1 was discharged from the hospital and admitted to the nursing home and lived there for maybe a week. Resident #1's family member stated he and Resident #1's family visited often and had observed no one would assist Resident #1 reposition and or provide incontinent care and many times the family would intervene and insist the staff provide care. Resident #1's family member stated he learned that on 5/18/2026 Resident #1 was sent to the hospital for an infection. Resident #1's family member stated he was given a report on 5/21/2026, by the hospital nurses that Resident #1 had an ulcer to her backside / buttocks and neck areas and may have contributed to her diagnosis of systemic infection. Resident #1's family member stated he grew upset and recalled there were days when he and Resident #1's family visited Resident #1, and no one had provided care. Resident #1's family member stated he called the nursing home to complain. Resident #1's famiy member stated he reached the DON and she heard his complain but he felt she was defensive and indifferent. During an interview on 5/23/2026 at 11:40 AM DON stated Resident #1 was admitted on [DATE] for LTC rehabilitation with ADL supports complicated by a left knee surgery after a fall she had at home. The DON stated Resident #1 was assessed with a change of condition on the morning of 5/18/2026 by the NP, the facility supported the NP's orders for Resident #1 to be sent to the hospital for evaluation and treatment. The DON stated she had received a phone call from Resident #1's Representative on or about 5/21/2026 who was upset that Resident #1 had pressure ulcers to her back / buttocks. The DON stated she had discussed the complaint with the Administrator, and they concluded the allegation was without merit as the interviews and record reviews revealed LVN A and LVN B had administered an enema on the evening of 5/17/2026 and neither nurse observed any skin breakdown. The DON stated the Administrator and herself decided the allegation did not rise to the level of a self-report to the state agency since the allegation had no evidence. A record review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, dated April 2001, revealed . policy interpretation and implementation: . Identify and investigate all possible incidents of abuse, neglect, mistreatment, poor misappropriation of resident property. Investigate and report any allegations within time frames required by federal requirements.