

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/12/2026
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)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access for 2 of 11 Residents (Resident #118 and Resident #162) and 1 of 5 medication carts (100 Hall Medication Aide Cart) reviewed for medication storage:1. The facility failed to ensure Resident #162 did not have a prescription medication of Mupirocin Ointment 2% at the bedside.2. The facility failed to ensure the 100 Hall Medication Aide Cart was not unlocked and unattended. 3. The facility failed to ensure Resident #118 did not have medication in their room. These failures could affect residents who received medications in the facility and place them at risk for not receiving the correct medications, medication misuse or drug diversion. The findings included: 1. Record review of Resident #162's face sheet dated 6/11/26 reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included acute osteomyelitis (infection and inflammation of the bone caused by bacteria) of left foot and ankle, diabetes (chronic disease in which the body cannot properly regulate sugar levels), kidney transplant status, and peripheral vascular disease (condition in which the blood vessels outside the heart and brain become narrowed, blocked, or damaged, reducing blood flow). Record review of Resident #162's Order Summary Report dated 6/9/26 reflected the resident did not have a physician's order for Mupirocin Ointment 2%. During an observation on 6/9/26 at 9:41 a.m., Resident #162 was observed sleeping in bed and a prescription medication of Mupirocin Ointment 2% with a pharmacy label that had the resident's name on it was observed on the bedside table on the left side of the resident's bed. During an observation on 6/9/26 at 10:52 a.m., Resident #162 was not in the room and a prescription medication of Mupirocin Ointment 2% with a pharmacy label that had the resident's name on it was observed on the bedside table on the left side of the resident's bed. During an observation and interview on 6/9/26 at 3:26 p.m., Resident #162 stated she had been admitted into the facility from the hospital maybe 5 or 6 days ago and any medications she had when she was admitted to the facility were held by the facility nursing staff. Resident #162 stated she had been told by the facility nursing staff that she was not supposed to have medications at the bedside and if she had, she would have to give them up to the nurses. Resident #162 stated, the prescription medication of Mupirocin Ointment 2% observed on the bedside table was given to her by the hospital (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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and had been on the bedside table since she admitted . Resident #162 stated she did not know what the prescription medication of Mupirocin Ointment 2% was for, and nobody's ever said anything about it and it had always remained on the bedside table. During an interview on 6/9/26 at 3:34 p.m., LVN I stated there were no residents in the unit where Resident #162 resided who were allowed to self-administer medication. LVN I stated, a resident in the facility who was allowed to self-administer medication first had to be observed to ensure the resident was able to self-administer medications, and a physician's order was required. During an observation and interview on 6/9/26 at 3:40 p.m., LVN I, after she observed the Mupirocin Ointment 2% prescription medication on Resident #162's bedside stated the resident was not allowed to have the medication at the bedside and only nursing staff were supposed to administer the resident her medications. LVN I stated, Resident #162 would need an assessment and a physician's order to be allowed to self-administer medications. LVN I stated, medications at the bedside could potentially lead to the medication being obtained by a person who was not alert and oriented and could ingest it or use the medication improperly. LVN I stated, nursing staff and CNA staff monitored items such as medications left at the bedside during rounds. During an interview on 6/11/26 at 2:06 p.m., the DON stated there were no residents in the facility who were allowed to keep medications at the bedside. The DON stated, residents who wanted to self-administer medications had to have their BIMS score checked, obtain permission from the physician to allow the resident to self-administer medications, and if the physician approved, then the resident would require an assessment to safely self-administer medications. The DON stated, if the resident was deemed capable of self-administering medications, then the physician orders would have to be updated and then it would be care-planned. The DON stated, without following the process, the resident could not keep medications at the bedside, regardless of whether the medication was over the counter or had a pharmacy label. The DON stated that medications left at the bedside not prescribed by the doctor could result in the resident having an adverse reaction. The DON stated the nurse managers or administrative team made rounds daily, multiple times looking for objects that should not be at the bedside such as medications, sharps, and aerosol air fresheners. 2. During an observation on 6/9/26 at 12:50 p.m. revealed the 100 Hall Medication Aide cart was unlocked and unattended next to the medication room facing the walkway in front of the nurse's station. During an interview on 6/9/26 at 12:55 p.m., RN G, who was sitting behind the nurse's station with her back to the 100 Hall Medication Aide Cart stated the medication cart was assigned to Medication Aide H. RN G stated the problem with an unattended and unlocked medication cart was that anybody could get into it and take a medication that did not belong to them and could have an adverse reaction. RN G stated, if a person ingested a medication taken from the unattended, unlocked medication cart and had an adverse reaction, we would not even be able to tell the doctor what the person took if medications were taken from the cart. During an interview on 6/9/26 at 12:59 p.m., Medication Aide H stated she had been assigned the 100 Hall Medication Cart since the beginning of her shift beginning at 6:00 a.m., and stated she last used the 100 Hall Medication cart about 7 minutes ago. Medication Aide H stated she had forgotten to lock the 100 Hall Medication cart and stated she had the key with her. Medication Aide H stated, when a medication cart was left unattended and unlocked anybody could come and take or steal a medication not prescribed for them and could result in an adverse reaction. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/11/26 at 2:14 p.m., the DON stated it was her expectation that the medication carts should always be locked when unattended because residents who wander can get into the cart which could result in ingesting a medication that did not belong to them and they could have an adverse reaction. 3.Record review of Resident #118's face sheet dated 06/12/2026 revealed a [AGE] year-old male readmitted to the facility on [DATE], with an original admission date of 04/04/2015, with diagnoses that include major depressive disorder, recurrent, mild (repeated episodes of depression that are currently mild in severity) and memory deficit following nontraumatic subarachnoid hemorrhage (bleeding in the space surrounding the brain which can lead to neurological deficits) . Record review of Resident #118's MDS dated [DATE] revealed a BIMS of 14 out of 15 indicating no cognitive impairment. Record review of Resident #118's care plan provided on 06/12/2026 revealed a focus area for the following: Is at risk for adverse reaction r/t medications, revised on 03/03/2021, with interventions including discuss with resident and family the number and type of medications resident is taking and the potential for drug interactions and side effects from over-medication, with an initiation date of 03/03/2021. During an observation and interview on 06/10/2026 at 9:10 a.m., revealed Resident #118 had 1 container of Vapor Rub in an open storage container on their bedside table. Resident #118 stated staff knew he had the Vapor Rub and if he was not allowed to have it, they would have taken it away because staff take away things residents cannot have. Resident #118 stated he used the Vapor rub for allergies and would put it under his nose. Resident #118 stated they occasionally have had other residents come visit him in his room. During an interview on 06/11/2026 at 9:05 a.m., CNA B stated residents were not allowed to have medication in their room and if they did, CNA B would have to let a nurse know. CNA B stated they were not sure if Resident #118 should not have Vapor Rub in their room. CNA B stated they did not know Vapor Rub and/or Chest Rub were medications but instead thought they were just creams. CNA B stated they had not seen residents wander into other residents' rooms or visit other residents in their rooms. CNA B stated the risk to residents that had Vapor Rub in their room could be ingestion but thought that Resident #118 would not do that. During an interview on 06/11/2026 at 9:15 a.m., LVN C stated residents could not have medication in their rooms unless they had a signed consent. LVN C stated they were not sure if Resident #118 should not have Vapor Rub in their room. LVN C stated they had seen residents go in and out of other residents' rooms to visit but not wander. LVN C stated the danger of having Vapor Rub in the resident's room could be the medication side effects or risk of ingestion. During an interview on 06/11/2026 at 11:19 a.m., the DON stated residents should not have medication in their room. The DON stated if residents could have medication in their room, they would have a physician's order for it as well as a safe administration of drug assessment completed. The DON stated if staff saw prohibited items in residents' rooms, they were to remove them and let the nurse know. The DON stated rotating staff were assigned rounds daily that were used to look for items residents should not have in their rooms. The DON stated they did not see safe administration (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	drug assessments completed for Resident #118. The DON stated they were not aware Resident #118 had Vapor Rub in their room. The DON stated the risks could be that other residents could get into it or a resident with dementia could get ahold of it. Record review of the facility document titled Medication Access and Storage with revision date 8/2020 reflected in part. It is the policy of this facility to store all drugs and biological (sic) in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (e.g., medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.		

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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. Based on observation, interview, and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for service safety for 1 of 1 kitchen. The facility stored one food item without the manufacturer's use-by date and one food item beyond the manufacturer's use-by date. 2. The facility failed to ensure pureed bread and baked beans were maintained at the required holding temperature of 135 degrees on the steam table. These deficient practices had the potential to place residents at risk for consuming unsafe food and developing foodborne illness. Findings included: 1. Observation on 06/09/2026 at 9:15 a.m. during the initial kitchen tour revealed a box of taco shells stored in the facility's dry storage area with a manufacturer's use-by date of 03/19/2026. During the same observation, a box of frozen cookie dough was observed in the freezer and labeled with a handwritten date of 02/03/2026. The manufacturer's use-by date had been removed from the packaging and was not available for review. During an interview on 06/09/2026 at 9:30 a.m., the Dietary Manager stated he was responsible for monitoring food inventory and routinely checking food dates. The Dietary Manager stated he had not realized the expired taco shells remained in storage. The Dietary Manager stated the handwritten date on the cookie dough represented the date staff opened the product. The Dietary Manager confirmed the manufacturer's use-by date had been removed from the cookie dough packaging and stated he was unable to determine the manufacturer's use-by date, when the product should be discarded, when it was last used, or whether the product remained suitable for use. The Dietary Manager stated expired or unsuitable food products could place residents at risk for foodborne illness. A review of the Texas Health and Human Services Retail Food Code, Chapter 228, on 06/09/2026 revealed food items maintained in inventory must be properly identified and maintained in a manner that allows determination of appropriate use and discard dates. A review of dietary staff training records on 06/09/2026 revealed the Dietary Manager maintained current ServSafe Food Safety Certification and [NAME] A had completed ServSafe Food Safety training. 2. Observation and interview on 06/10/2026 at 11:45 a.m. during meal service revealed [NAME] A conducting temperature checks of food items held on the steam table. Temperature checks revealed Pureed bread measured 118 F and baked beans measured 121 F. [NAME] A was unable to identify the correct temperature. The Dietary Manager stated the required hot-holding temperature was 135 F or higher. The Dietary Manager stated the food items would be reheated prior to service. The pureed bread and baked beans were removed from the steam table and reheated. Follow-up temperature checks revealed the pureed bread measured 136 F and the baked beans measured 144 F, after which the food items were returned to service. During an interview on 06/10/2026 at 11:50a.m., the Dietary Manager stated hot food items should be maintained at 135 F or above while being held for service. The Dietary Manager stated serving food below the required holding temperature could place residents at risk for foodborne illness. Review of the facility Policy from Texas Food Establishment Rules, Texas Administrative Code, Title 25, Part 1, Chapter 228 revealed hot-held food must be maintained at 135 F or above during holding and service. Review of dietary staff training records revealed the Dietary Manager completed SERV Safe food safety certification on 02/12/2025 and [NAME] A completed SERV Safe food safety training on 08/22/2024.		

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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** Based on interview and record review, the facility failed to ensure residents have the right to formulate an advance directive for 2 of 3 residents (Residents #153 and #162) reviewed for advanced directives: The facility failed to determine upon admission whether Resident #153 and Resident #162 had an advanced directive, and if not, determined whether the Resident or Resident Representative wished to formulate an advanced directive. This deficient practice could place residents at risk of not having their wishes known, which could affect whether they receive medical treatment according to their rights. The findings included: 1. Record review of Resident #153's face sheet dated [DATE] reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included acute osteomyelitis (infection and inflammation of the bone caused by bacteria) of left foot and ankle, diabetes (chronic disease in which the body cannot properly regulate sugar levels), kidney transplant status, and peripheral vascular disease (condition in which the blood vessels outside the heart and brain become narrowed, blocked, or damaged, reducing blood flow). Record review of Resident #153's Order Summary Report dated [DATE] reflected the resident had an order for CPR/Full Code with order date [DATE] and no end date. Record review of Resident #153's comprehensive care plan dated [DATE] reflected the resident had elected Full Code status with interventions that included to update the resident's clinical record to reflect elected code status. Record review of Resident #153's clinical record reflected there was no Advance Directive Acknowledgement document in the resident's record. 2. Record review of Resident #162's face sheet dated [DATE] reflected an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included diabetes, chronic obstructive pulmonary disease (progressive lung disease that causes airflow blockage and makes it difficult to breathe), congestive heart failure (chronic condition in which the heart cannot pump blood effectively enough to meet the body's needs), peripheral vascular disease, and acquired absence of right leg above the knee. Record review of Resident #162's Order Summary Report dated [DATE] reflected the resident had an order for CPR/Full Code with order date [DATE] and no end date. Record review of Resident #162's comprehensive care plan dated [DATE] reflected the resident had elected Full Code status with interventions that included to update the resident's clinical record to reflect elected code status. Record review of Resident #162's clinical record reflected there was no Advance Directive Acknowledgement document in the resident's record. During an interview on [DATE] at 1:20 p.m., the DON stated that the opportunity for a resident to formulate an advanced directive was provided by the SW at the time of admission and was reviewed during care plan meetings. The DON stated the Advance Directive Acknowledgement document was found in the resident's electronic record, but the SW oversaw that. During an interview on [DATE] at 1:39 p.m., Resident #162 stated she recalled a discussion about an advance directive but was not sure with whom she had the discussion and stated she did not sign a document referencing advance directives. Resident #162 stated she was currently on Full Code status and wanted to continue Full Code status. During an interview on [DATE] at 1:43 p.m., Resident #153 stated he recalled a discussion with his family member regarding an advanced directive. Resident #153 stated he wanted to remain on Full Code status but discussed with his family member the possibility of a DNR status if he should become brain dead. Resident #153 stated he was not sure if his family member had signed a document related to an advanced directive. During a telephone interview on [DATE] at 2:39 p.m., Resident #153's family member stated she recalled possibly having discussed an advanced directive with the SW but was not sure about signing a document referencing an advanced directive. During an interview on [DATE] at 3:47 p.m., the SW stated that code status and power of attorney discussions were held with the residents and/or family members at time of admission. The SW stated, the Advance Directive Acknowledgement document should be signed a few days after admission and then the document was supposed to be scanned into (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the residents' clinical record and could be found in the Documents section of the record. The SW stated she was responsible for providing newly admitted residents or their families with the Advance Directive Acknowledgement document and she was also responsible for uploading the document into the resident record. The SW stated she did not generate the Advance Directive Acknowledgement document for Resident #153 and Resident #162 because she had been busy. The SW stated, the Advance Directive Acknowledgement document was a big deal because the acknowledgement proved that the discussion to formulate an advance directive took place and it showed what the resident or family's preference was. During a follow up interview on [DATE] at 7:48 a.m., the DON stated residents on full code status were identified in the clinical record, and the Advance Directive Acknowledgement was important to ensure the correct information was in the clinical record and the resident's wishes were carried out. During an interview on [DATE] at 8:08 a.m., the Administrator stated the Advance Directive Acknowledgement was an important document and efforts needed to be made to ensure it was completed. The Administrator stated the Advance Directive Acknowledgement determined how to care for the residents. Record review of the facility document titled Advance Directives and Associated Documentation with revision dated 12/2023 reflected in part, .It is the policy of this facility that a resident's choice about advance directives will be recognized and respected. Further, it is the policy of this facility to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. Procedure. Prior to, upon, or immediately after admission, a facility staff member shall: a. Provide the resident/family or responsible agent written information regarding the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives. b. Document in the resident health record that, at the time of admission, the resident and/or resident representative have been provided with written information regarding advance directives. Record review of the facility document titled Medical Record, Content of with revision date 8/2007 reflected in part, .The resident's medical record shall contain at least the following information .Consents/Authorizations/Acknowledgments. Appropriate consent forms, authorizations and acknowledgments are signed by the resident or legal representative and entered in the medical record .These include, but are not limited to, the following .Acknowledgement of receipt of advance directive information .List of contents of the medical record .Advance Directive Acknowledgment .		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident's environment remains as free of accident hazards as is possible, for 1 of 6 residents (Resident #118), reviewed for accidents. The facility failed to ensure Resident #118 did not have a pair of nail clippers in their room. This failure could place the resident at risk of injury and contribute to avoidable accidents and a decline in health. The findings include: Record review of Resident #118's face sheet dated 06/12/2026 revealed a [AGE] year-old male readmitted to the facility on [DATE], with an original admission date of 04/04/2015, with diagnoses that include major depressive disorder, recurrent, mild (repeated episodes of depression that are currently mild in severity) and memory deficit following nontraumatic subarachnoid hemorrhage (bleeding in the space surrounding the brain which can lead to neurological deficits). Record review of Resident #118's MDS dated [DATE] revealed a BIMS of 14 out of 15 indicating no cognitive impairment and recorded the needed use of substantial/maximal assistance with personal hygiene. Record review of Resident #118's care plan provided on 06/12/2026 revealed a focus area for the following: ADL self-care performance deficit r/t UTI revised on 02/17/2026, with interventions including Personal hygiene: Set Up initiated on 02/17/2026. During an observation and interview on 06/09/2026 at 10:16 a.m., revealed Resident #118 had 1 pair of nail clippers in their clear storage container on their dresser. Resident #118 stated staff knew he had the nail clippers and if he was not allowed to have them, they would have taken them away because staff take away things residents cannot have. During an observation and interview on 06/10/2026 at 9:10 a.m., revealed Resident #118 had 1 pair of nail clippers in their clear storage container on their dresser. Resident #118 stated he could not cut his nails and that his family comes and does it. Resident #118 stated they had not cut themselves with nail clippers. Resident #118 stated they occasionally have had other residents come visit him in his room. During an interview on 06/11/2026 at 9:05 a.m., CNA B stated residents were not allowed to have harmful items such as nail clippers in their rooms and if they did, CNA B would have to let a nurse know. CNA B stated they were not sure if Resident #118 should not have nail clippers in their room. CNA B stated they had not seen residents wander into other residents' rooms or visit other residents in their rooms. CNA B stated the risk to residents that had nail clippers in their room would be residents could have cut themselves or the item could be harmful. During an interview on 06/11/2026 at 9:15 a.m., LVN C stated residents could not have anything they could use to harm themselves. LVN C stated Resident #118 should not have nail clippers in their room. LVN C stated they had seen residents go in and out of other residents' rooms to visit but not wander. LVN C stated the danger of having nail clippers in the resident's room could be cutting themselves or using it as a weapon. During an interview on 06/11/2026 at 11:19 a.m., the DON stated residents should not have nail clippers in their room. The DON stated if residents could have nail clippers in their room, they would have to have a safety assessment completed to ensure they were safe to have and use the items. The DON stated if staff saw prohibited items in residents' rooms, they were to remove them and let the nurse know. The DON stated rotating staff were assigned rounds daily that were used to look for items residents should not have in their rooms. The DON stated they did not see safety assessments completed for Resident #118. The DON stated they were unaware that Resident #118 had nail clippers in their room. The DON stated the risks could be residents could cut themselves, infection and a safety risk. Record review of the facility's policy titled, Resident Rights, no date, revealed: The resident has the right: 16. To keep and use personal clothing and possessions in the nursing center as space permits unless doing so would infringe upon the rights or safety of other residents. Record review of facility's policy titled, Hazardous Items, revised 05/2024, revealed: It is policy of this facility to ensure that hazardous items get disposed of properly.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 6 residents (Residents #11) reviewed for accuracy of records: The facility failed to ensure Resident #11 had the correct order for their DNR code status. The failure could affect residents whose records were maintained by the facility and could place the residents at risk of errors in care and treatment. The findings include: Record review of Resident #11's face sheet dated 06/10/2026 revealed a [AGE] year-old male readmitted to the facility on [DATE], with an original admission date of 09/14/2023, with diagnoses that include chronic respiratory failure, unspecified whether with hypoxia or hypercapnia (the lungs cannot adequately exchange gases, leading to insufficient oxygen or excess carbon dioxide in the blood) and heart failure (heart muscle unable to pump enough blood to meet the body's needs for blood and oxygen). Record review of Resident #11's MDS dated [DATE] revealed a BIMS of 14 out of 15 indicating no cognitive impairment. Record review of Resident #11's care plan provided on 06/10/2026 revealed a focus area for the following: [Resident #11] . has elected to change his full code status (the patient wishes to receive all possible life-saving interventions if their heart or breathing stops) on 1/11/24 to DNR code status and has initiated OOHDNR, OOHDNR has been scanned into record revised on 01/12/2024, with interventions including Do Not Resuscitate in the event of cardiac arrest initiated on 01/12/2024. Record review of Resident #11's order summary, dated 06/10/2026, revealed an active full code order with an order date of 04/02/2026. Record review of Resident #11's out-of-hospital do-not-resuscitate (OOH-DNR) order form revealed it had been signed by Resident #11 and the physician on 1/11/2024 and notarized on 1/11/2024. Record review of Resident #11's acknowledgement of advance care planning signed by Resident #11 on 1/11/2024 revealed Resident #11 checked off the following section I/Family have executed an out of hospital do not resuscitate (OOHDNR) form and expect my wishes will be honored and respected. During an interview on 06/11/2026 at 11:19 a.m., the DON stated either themselves or the social worker were in charge of ensuring the code status for residents was changed if the resident decided they would like it changed. The DON confirmed that Resident #11 had an order to be a full code and Resident #11's care plan reflected that Resident #11 was a DNR. The DON stated they would have to verify with the social worker regarding what Resident #11's code status was. The DON stated the risk of an incorrect code status order could be that the facility could not have honored the residents' wishes. During an interview on 06/11/2026 at 11:38 a.m., the SW stated if a resident changed their mind about their code status the SW would let the nurse know and then the nurse would put in an order and the physician would sign off on the order which would change the resident's code status. The SW stated Resident #11 previously discharged from the facility and that the nurse may not have changed it back when Resident #11 readmitted to the facility again. The SW stated when Resident #11 readmitted the nurse readmitted Resident #11 as a full code and Resident #11 should have been a DNR. During an interview on 06/11/2026 at 11:46 a.m., Resident #11 confirmed he had changed his code status to a DNR and that during every care plan meeting had, the nursing staff would go over their code status to ensure the residents knew. During an interview on 06/11/2026 at 2:51 p.m., ADON D stated they were covering as nurse for the hall Resident #11 was on. ADON D stated that when a resident's code status changed typically the doctor will inform the SW. ADON D stated that usually the nurse submits the order of the resident's code status when the resident is admitted to the facility. ADON D stated the incorrect code status order could lead to harm to the resident. During an interview on 06/12/2026 at 9:04 a.m., the DON stated once the SW receives the resident's DNR, complete and verified, the SW would have either let the DON or someone in upper management know and if not present then the SW would the nurse know so they could put in the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 06/12/2026
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.			
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order. During an interview on 6/12/2026 at 9:06 a.m., the SW stated when a resident wanted to change from a full code to DNR the SW would notify the doctor and get the paperwork signed and then would notify the nurse who would discontinue the full code order and submit a new DNR order to the physician. The SW stated the risk of an incorrect code status order could be a big issue legally and for the facility and family. Record review of facility's policy titled, Medical Record, Content of, revised on 08/2007, revealed the following: All physicians, nursing staff and other health professionals involved in the resident's care will be responsible for making prompt, appropriate entries in the record. Record review of the facility's policy titled, Advance Directives and Associate Documentation, revised on 12/2023, revealed the following: It is the policy of this facility that a resident's choice about advance directives will be recognized and respected.		

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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** Based on observation, interview, and record review, 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 2 of 6 residents (Residents #10 and #31) reviewed for infection control: The facility failed to ensure Resident #10's indwelling urinary catheter tube and urine bag were not resting on the floor and Medication Aide E used appropriate hand hygiene when moving from a clean area to a dirty area when administering medications to Resident #31. These failures could place residents at risk for cross-contamination and infection and could result in illness due to improper care practices. The findings included: 1. Record review of Resident #10's face sheet dated 6/9/26 reflected an [AGE] year-old female admitted into the facility on 4/16/26 with diagnoses that included sepsis (a life-threatening emergency that occurs when the body's response to an infection causes widespread inflammation and organ dysfunction), kidney failure (a condition in which the kidneys can no longer adequately filter waste products, excess fluid, and toxins from the blood), urinary tract infection (an infection that can occur anywhere in the urinary system), uterovaginal prolapse (a condition where the uterus [womb] slips down from its normal position into or through the vaginal wall causing difficulty with urination), and need for assistance with personal care. Record review of Resident #10's most recent comprehensive MDS assessment dated [DATE] reflected the resident was severely cognitively impaired for daily decision-making skills and utilized an indwelling urinary catheter. Record review of Resident #10's Order Summary Report dated 6/9/26 reflected the following: - Secure (urinary) catheter with a leg strap/leg band or anchor to minimize catheter related injury and accidental removal or obstruction or urine outflow, check placement every shift with order dated 4/16/26 and no end date. Record review of Resident #10's comprehensive care plan with revision date 4/17/26 reflected the resident utilized an indwelling urinary catheter related to retention due to a prolapsed uterus with interventions that included to secure the catheter to facilitate flow of urine, prevent kinking of tubing, and accidental removal. During an observation on 6/9/26 at 12:06 p.m., Resident #10 was observed sitting up in the wheelchair while eating lunch in the dining room and the indwelling urinary tube and urine bag were resting on the floor. During an observation and interview on 6/9/26 at 12:10 p.m., ADON F observed Resident #10's indwelling urinary tube and urine bag were resting on the floor. ADON F stated, the indwelling urinary tube and urine bag should not be resting on the floor because they could have leaks, or it could cause injury if dislodged. ADON F stated, the indwelling urinary tube and urine bag resting on the floor was considered an infection control issue and cross contamination and could result in the resident having trauma or put the resident at risk for infection, such as a urinary tract infection. ADON F stated, the nurses and medical staff were responsible for ensuring the indwelling urinary tube and urine bag were kept off the floor, and other staff such as therapy staff could make the nursing staff aware that it was occurring. ADON F stated, it's an easy fix. 2. Record review of Resident #31's face sheet dated 6/10/26 reflected a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included diabetes with diabetic cataract (a clouding of the eye's natural lens that develops as a result of diabetes), bilateral myopia (a vision condition in which near objects can be seen clearly, but distant objects appear blurry), and need for assistance with personal care. Record review of Resident #31's most recent quarterly MDS assessment dated [DATE] reflected the resident was cognitively intact for daily decision-making skills and had impaired vision that required corrective lenses. Record review of Resident #31's Order Summary Report dated 6/10/26 reflected the following: - Systane Solution 0.4-0.3%, instill 1 drop in both eyes four times a day for dry eyes with order dated 3/12/26 and no end date. Observation on 6/10/26 at 8:22 a.m. during the medication pass revealed Medication Aide E, after administering oral medications to Resident #31, returned to the medication cart, did not wash or sanitize his hands, and put on a pair of gloves. Medication Aide E (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then took the keys and unlocked the medication cart, retrieved the Systane Solution from the medication cart, and placed the keys in his right pocket. Medication Aide E, while still wearing the gloves, returned to Resident #31's bedside and instilled the Systane drops into the resident's eyes. During an interview on 6/10/26 at 8:27 a.m., Medication Aide E stated he had not realized he did not perform hand hygiene before putting on a pair of gloves or when moving from a clean area to a dirty area. Medication Aide E stated, hand hygiene must be utilized before and after glove changes. Medication Aide E stated, when administering eye drops, your hands need to be clean, as clean as possible, and was considered basic infection control practices. Medication Aide E stated, not using proper hand hygiene practices was considered cross contamination and the resident could get an infection, including an eye infection. During an interview on 6/11/26 at 2:14 p.m., the DON stated, Medication Aide E should have sanitized his hands before putting on a pair of gloves. The DON stated, if gloves were worn while preparing medications, then the gloves should have been removed, and hand hygiene should have been utilized before putting on a new pair of gloves and before administering eye drops which would help to prevent spread of infection. During a follow-up interview on 6/12/26 at 8:32 a.m., the DON stated, it was not ok for a resident's indwelling urinary tube and urine bag to be touching the floor because it could possibly spread infection, and the indwelling urinary tube and urine bag could dislodge if stepped on accidentally. The DON stated it was her expectation that the indwelling urinary tube and urine bag be kept from touching the floor to prevent cross contamination. Record review of the facility document titled Catheter Drainage Bag with revision date 4/2025 reflected in part, .It is the policy of the facility to maintain continuously closed urinary drainage system whenever possible and provide a receptacle for urine. Catheter Drainage Bag.14. Position the drainage bag below the level of the resident's bladder and without resting on the floor. Ensure tubing allowed for unobstructed drainage of urine. Record review of the facility document titled Infection Prevention and Control Program with revision dated 4/2025 reflected in part, .The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. the elements of the infection prevention and control program consist of. prevention of infection. Process Surveillance is the review of practices by staff directly related to resident care. Some considerations for this process may include, but are not limited to. Hand hygiene. Infection control practices during the provision of resident care and treatments.		