STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676328	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Colinas of Westover	9738 Westover Hills Blvd 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48753 Based on interview and record review the facility failed to provide services that are furnished to maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 9 residents (#1 and #2) reviewed for care plans in that: 1. Resident #1's care plan did not indicate that she had a fall resulting in a shoulder fracture with interventions to include a sling to her left arm, fall mats and an orthopedic consult. 2. Resident #2's care plan did not indicate that she had a fall resulting in a finger fracture with interventions to include a finger splint. This deficient practice could place residents at risk of not having needs identified and interventions established. The findings were: 1. Review of resident #1's face sheet revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease (a progressive disease that affects memory and other important mental functions) and Ataxic Gait (impaired balance or coordination). Review of Resident #1's quarterly MDS, dated [DATE], revealed a BIMS of 3, indicating severe cognitive impairment. Review of Resident #1's care plan, dated 04/12/2024 and revised 04/23/2024, revealed that the care plan did not address a fall on 04/24/2024, resulting in a left shoulder fracture with interventions of a left arm sling, orthopedic consult and fall mats. Review of Resident #1's Fall Risk Assessment, dated 04/19/2024, revealed a score of 18 indicating Resident #1 was a high fall risk. Review of Resident #1's radiological x-ray report, conducted on 04/24/2024, revealed the bones were osteoporotic (brittle and fragile bones) and a left humeral neck nonunion fracture (shoulder fracture) was visualized. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's April 2024 Physician orders revealed an order from the physician on 04/24/2024 for a left arm sling and an order for an orthopedic consult. Observation of Resident #1, on 04/26/2024 at 1:45pm, revealed Resident #1 with a sling on her left arm. Interview with the DON on 04/30/2024 at 10:05am confirmed that Resident #1 did not have a care plan that addressed her fall which resulted in a shoulder fracture on 4/24/2024 with interventions that included a left arm sling, fall mats and an orthopedic consult placing the resident at risk for potential injuries or additional falls. During the interview, the DON stated she was responsible for updating resident care plans related to incidents and accidents. 2. Review of Resident #2's face sheet revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which include Cerebral Infarction (a disruption in the brain's blood flow), Dementia (a general term for impaired ability to remember, think, or make decisions) and Osteoporosis (brittle and fragile bones). Review of Resident #2's quarterly MDS, dated [DATE], revealed a BIMS score of 0 indicating a severe cognitive impairment. Review of Resident #2's care plan, dated 01/22/2024 and revised 04/22/2024, completed on 04/26/2024 did not address a hip fracture and non-displaced fracture of the middle finger resulting from a fall on 04/13/2024 with interventions to include a finger splint. Review of Resident #2's hospital discharge summary dated 04/19/2024 revealed an order for alumifoam finger splint to right hand. An observation of Resident #2 on 04/26/2024 at 1:10pm revealed a splint to her right middle finger. Interview with LVN A, 04/26/2024 at 1:22pm, revealed she had received training on fall prevention and stated interventions used to prevent further falls would be located in the resident's plan of care. She stated it is important to follow the residents plan of care because it is what is safe for the resident. Interview with RN A, 04/29/2024 at 10:40am, revealed she had received training on fall prevention and stated that she did have access to the resident's plan of care. She stated it is important to follow a resident's plan of care because for resident's who are a fall risk, they could get hurt or decline if we do not follow their plan of care. Interview with the DON, 04/30/2024 at 10:05am, revealed Resident #2 had a finger splint and confirmed the care plan had not been updated to reflect the changes in Resident #2's plan of care. The DON stated the care plan should be updated by the following day of a change in the resident's plan of care. She stated the staff have received training on abuse and neglect and fall prevention. Furthermore, when asked what harm could come to a resident who's care plan is not updated timely and followed, she stated possible injuries to the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility in-services on 04/30/2024 revealed staff had received education on fall risk prevention, including the addition of interventions to prevent further falls, on 03/31/2024 and 04/14/2024. Review of facility policy titled Falls and Fall Risk, Managing dated 2001 and revised March 2018, revealed the policy statement is based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try and minimize complications from falling. Review of the facility policy titled Care Plans, Comprehensive Person-Centered dated 2001 and revised March 2018, stated the comprehensive, person center care plan will: include measurable objectives and timeframes; describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; incorporate identified problem areas; incorporate risk factors associated with identified problems; aide in preventing or reducing decline in the resident's functional status and/or functional levels.