

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: 676328	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Las Colinas of Westover		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes enhancement of his or her quality of life, recognizing each resident's individuality for 3 of 7 Residents (Resident #71, Resident #101 and Resident #64) who were observed for ADL care. 1. LVN A stood while feeding Resident #71 her lunch meal on 9/24/24 and on 9/25/24. 2. LVN A stood while feeding Resident #101 her lunch meal on 9/25/24. 3. LVN B held the door open while a CNA was talking to him about Resident #64 exposing him to anyone walking down the hallway on 9/26/24. These deficient practices could affect dependent residents and contribute to feelings of shame or feeling uncomfortable. The findings were: 1. Review of Resident #71's face sheet, dated 9/27/24, revealed she was admitted to the facility on [DATE] with diagnosis including Dementia, Schizoaffective Disorder and Major Depressive Disorder, all dated 4/17/23. Review of Resident #71's quarterly MDS assessment, dated 07/25/24, revealed her BIMS was 0 meaning she was unable to complete the Brief Interview for Mental Status. Further review revealed she had a diagnosis of Depression and Schizophrenia and required supervision or touching assistance with eating. Review of Resident #71's Care Plan, revised 04/24/23, , revealed she had a nutritional problem or potential nutritional problem and staff was to encourage meal intake and provide and serve diet as ordered. Further review revealed there was no mention of whether Resident #71 required assistance with feeding. Observation on 09/24/24 at 12:00 to 12:13 PM revealed LVN A standing while feeding Resident #71. Resident #71 was eating her meal while periodically looking up at LVN A. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/25/24 from 12:01 PM revealed LVN A feeding Resident #71 while standing up. Resident #71 was eating all of her food while periodically looking up at LVN A. 2. Review of Resident #101's face sheet, dated 9/27/24, revealed she was admitted to the facility on [DATE] with diagnoses including Dementia and Major Depressive Disorder. Review of Resident #101's quarterly MDS assessment, dated 08/16/24, revealed her BIMS was 0 meaning she was unable to complete the Brief Interview for Mental Status. Further review revealed she required partial or moderate assistance with eating. Review of Resident #71's Care Plan, revised 04/24/23, , revealed she had State of nourishment; less than body requirement characterized by weight Loss, inadequate intake, decreased appetite related to: Cognitive Impairment and staff was to Serve large protein portions with all meals. However, there was no mention of whether or not she required assistance with feeding. Observation on 09/25/24 at 12:10 PM revealed LVN A feeding Resident #101 while standing up. Resident #101 was eating her food; constantly talking and grabbing at the spoon. Resident #101 was looking up at LVN A. LVN A sat the lunch tray on a bedside table away from Resident #101. Interview on 09/27/24 at 12:08 PM with LVN A revealed she usually stood while she fed the Residents because she would move from Resident to Resident and sometimes had to intervene related to behaviors. LVN A stated she had to be ready in case anything happened but stated she understood it was a dignity issue because she did not sit at the Resident's eye level and she looked down at them while feeding the Resident's. This caused the Resident's to look up at her. LVN A stated she had not received any formal training for feeding Residents but stated it made sense that she should sit so it allowed for a comfortable experience. 3. Review of Resident #64's face sheet, dated 09/27/24, revealed he was admitted to the facility on [DATE] with diagnoses including Parkinson's with Dyskinesia, with fluctuations and generalized muscle weakness. Review of Resident #64's annual MDS assessment, dated 9/14/24, revealed his BIMS was 4 indicating severe cognitive impairment. Further review revealed Resident #64 was dependent on staff for all ADL's. Review of Resident #64's Care Plan, dated 10/23/23, revealed, The resident has impaired cognitive function/impaired thought processes r/t Parkinson's, aging and The resident requires approaches that maximize involvement in daily decision making and activity. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 09/26/24 at 03:51 PM revealed LVN B at Resident #64's doorway holding the door open. There was a female staff member standing at Resident #64's bedside talking with LVN B. Resident #64 was turned on his right side. The linens were turned down and Resident #64 was lying in his brief exposed to anyone walking down the hallway. Further observation revealed the privacy curtain was not drawn around the bed exposing Resident #64. Interview with LVN B revealed the CNA was talking to him about Resident #64. He stated he did not completely close the door and the CNA had not drawn the privacy curtain. LVN B stated they should provide Resident #64 with privacy and dignity during care. Interview on 09/27/24 at 04:20 PM with the DON revealed staff should pull privacy curtain and close the door during Resident care. If staff were having a discussion, then they should either come out into the hallway or stay in the room and have their discussion without exposing the Resident and violating his dignity. Review of a facility policy, Quality of Life--Dignity, revised February 2020) read: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self -worth and self-esteem. 1. Residents are treated with dignity and respect at all times.		

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 27520 Based on observation, interview and record review the facility failed to post a notice of the availability of such reports (surveys, certifications, and complaint investigations) in areas of the facility that are prominent and accessible to the public for 3 of 4 days observed for required postings. The facility did not post a sign providing the location of the survey results binder. This deficient practice could affect any resident and result in residents not being informed of the survey results. The findings were: Interview with 8 residents during a group meeting on 09/26/24 at 01:37 PM revealed they were not familiar with the survey results and where they were stored. All 8 residents stated they had not seen a sign or a binder labeled survey results. Observation on 09/26/24 at 02:18 PM in the facility lobby area revealed a group of binders on the shelf on the right-hand side. Amongst the binders there was 1 binder labeled Survey Results; it was not easily visible. Further observation revealed there was not a sign letting the residents and the public know of the location of the survey results binder. Interview on 09/26/24 at 03:06 PM with the AD revealed she had not shared the location of the survey results binder with the resident's. She stated she thought it was up front in the lobby area. Observation and interview on 09/26/24 at 03:23 PM with the ADM revealed the survey binder was available with last survey results. The ADM stated he did not know he needed to post sign providing the locations of the survey result. He stated there was not a sign posted.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on interviews and record reviews, the facility failed to ensure all Pre-Admission Screening and Resident Review (PASARR) Level 1 residents with mental illness were provided with a PASARR Level II Evaluation and Assessment for 1 of 3 residents (#71) reviewed for PASARR services. The facility failed to identify Resident #71 as having diagnoses indicative of Mental Illness including Schizoaffective Disorder and Major Depressive Disorder on the PASARR screening which would require a PASARR Level II assessment. This deficient practices could place residents at risk to a diminished quality of life related to not receiving or benefiting from specialized services. Review of Resident #71's face sheet, dated 9/27/24, revealed she was admitted to the facility on [DATE] with diagnosis including Dementia, Schizoaffective Disorder and Major Depressive Disorder, all dated 4/17/23. Review of Resident #71's quarterly MDS assessment, dated 7/25/24, revealed her BIMS was 0 meaning she was unable to complete the Brief Interview for Mental Status. Further review revealed she had a diagnosis of Depression and Schizophrenia. Review of Resident #71's Care Plan, revised 4/22/24, , revealed she had a diagnosis of Schizophrenia and Major Depressive Disorder. One of the interventions included Give medications as ordered. Monitor/document for side effects and effectiveness. Review of Resident #71's PASARR Level 1 Screening, dated 4/17/23, revealed she did not have a mental illness. Interview on 09/27/24 at 04:13 PM with the MDS Coordinator revealed Resident #71 had diagnoses including Schizoaffective Disorder and Major Depressive Disorder; however, had not re-submitted a Level I screening because she understood that she would not qualify for services because she had a primary diagnosis of Dementia. The MDS Coordinator stated she understood she was still required to submit a Level I screening to update them on Resident #71's diagnoses. Review of facility policy, Preadmission Screening and Resident Review (PASARR), undated, read: All persons who reside in a nursing facility are subject to Resident Review. If there is a substantial change in their mental status (receive a new mental health diagnosis) a new Level I will be performed and a Level II would be initiated by the Local Authority if deemed appropriate per their guidelines.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to ensure the resident's baseline Care Plan to include the minimum healthcare information necessary to properly care for a resident for 1 of 6 Residents (Resident #160) whose records were reviewed. Nursing staff failed to include Resident #160 used two 1/4 side rails while in bed for mobility. This deficient practice could affect residents who used side rails and could result in residents not receiving the equipment they needed for mobility. The findings were: Review of Resident #160's face sheet, dated 9/27/24, revealed she was admitted to the facility on [DATE] with diagnoses including Other Malaise. Further review revealed Resident #160 had been in the facility 9 days. Review of Resident #160's EHR revealed an MDS had not been completed because it was not due until day 14 per RAI. Review of Resident #160's Baseline Care Plan, dated 9/18/24, revealed she was cognitively intact. Further review revealed under section H., Resident #160 did not use any safety devices. Review of Resident #160's Bed Rail Evaluation, dated 9/18/24, revealed bed rails are indicated and serve as an enabler. Review of Resident #160's Bed Rail Consent, dated 9/18/24, revealed it was signed. However, the signer did not check off in the check box confirming the use of side rail. Observation on 09/24/24 at 10:04 AM revealed Resident #160 was lying in bed with two 1/4 side rail's up. Observation on 09/26/24 at 9:55 AM revealed Resident #160 sitting in a recliner with oxygen infusing at 2L. Further observation revealed two side rails were up on the bed. Interview with Resident #160 stated she asked for the use of side rails upon admission because she was very weak. She stated they helped her for bed mobility and to assist in sitting up in bed to prepare for transfers out of bed. Interview on 09/27/24 at 04:13 PM with the MDS Coordinator and the DON revealed Resident #160's Baseline Care Plan should reflect the use of side rails as an enabler to ensure they were available for Resident #160. (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy, Care Plans-Baseline, revised December 2016, read: A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. 1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. 3. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan.		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42031 Based on observation, interview, and record review the facility failed to ensure a resident received proper treatment and care to maintain mobility and good foot health, and provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and assist the resident in making appointments with a qualified person for 1 of 5 residents (Resident #52) reviewed for quality of care. Resident #52 did not see a podiatrist despite having thickened toenails and other foot concerns and the request of the resident's RP. This failure could place residents at risk of pain, difficulty wearing socks and or shoes, and could result in embarrassment, frustration, anxiety, and a decreased quality of life. The findings were: Record review of Resident #52's face sheet dated 9/27/24 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with readmission on 4/11/24. His diagnoses included cerebral infarction (also known as a stroke-refers to damage to tissues in the brain due to a loss of oxygen to the area), Dysarthria following cerebral infarction (a motor speech disorder that makes it difficult to form and pronounce words after a stroke), unspecified protein-calorie malnutrition (a disorder caused by a lack of proper nutrition or an inability to absorb nutrients from food), and unsteadiness of feet. Record review of Resident #52's undated care plan revealed a focus initiated on 6/14/24 and revised on 9/24/24 the resident had a right great toe arterial ulcer (open area due to inadequate blood supply to the affected area) with a goal target date of 11/23/24 to be free of infection or complications. Interventions included to avoid mechanical trauma: Constrictive shoes, Vigorous massage, and to inspect and notify the physician of changes. Record review of Resident #52's quarterly MDS assessment dated [DATE] indicated the resident was usually understood and usually understands others, had a BIMS score of 3 out of 15 indicating the resident was severely cognitively impaired. The resident had felt down, depressed, or hopeless 2-6 days of the previous 2 weeks. The resident used a wheelchair and required substantial-maximal assistance for putting on or taking off socks and shoes where the helper does more than half of the effort and partial-moderate assistance where the helper does less than half of the effort for lying to sitting on the side of the bed, sit to stand, chair/bed to chair transfers, shower, tub, toilet transfers, and walking was not attempted due to medical conditions. The resident was always incontinent of bowel and bladder. The resident had one open area on his foot from an arterial or venous ulcer and family was involved in his care and goal setting. Record review of Resident #52's Physician orders revealed an order with a start date of 6/13/24 for Right Great Toe Arterial Wound: Cleanse area with wound cleanser or NS (Normal Saline), pat dry with 4x4 gauze, paint with betadine and LOTA (Leave Open To Air) daily every day shift for wound care. (continued on next page)		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #52's Physician orders revealed an order with a start date of 9/11/24 for Right 4th Toe Arterial Wound: Cleanse area with wound cleanser or NS, pat dry with 4x4 gauze, paint with betadine, and LOTA daily every day shift for arterial wound. Record review of Resident #52's weekly skin assessment dated [DATE] revealed the resident had an existing arterial ulcer to his right great toe measuring 1.0cm by 0.5cm (centimeters) and a new arterial wound to his right 4th toe measuring 0.3cm by 1.0cm. The question were the nails cleaned and trimmed was answered with a no. There was no documentation of nail thickness or overgrowth. Record review of Resident #52's EHR revealed no documentation, orders, appointments, or recommendations for Podiatry or toenail trimming or general foot and nail care. Record review of facility contracted Podiatry visit and treatment lists from 8/5/24 and 9/25/24 revealed Resident #52 was not on the list to be seen by the podiatrist and was not seen by the podiatrist. In an observation and interview on 9/24/24 at 10:14 a.m. Resident #52 was lying in bed resting and he was covered with a sheet but his feet, ankles, and lower calves uncovered. The resident stated he was doing okay but needed his toenails trimmed and gestured with his hand to his feet in frustration. The resident stated he had no pain but the nail trimming not being done was his only concern. Observed the resident right great toe with a red open area on the tip of the toe but was not bleeding. The right great toenail had grown up and folded back over itself making the toenail approximately 1/2 to 3/4 inch thick in different areas. The right great toenail was yellow and whitish in different areas and had the appearance of a glob of bubbles on top of his toe but was not clear. The residents right 4th toe was turned slightly towards the great toe and the toenail was thin but approximately 1/4 - 1/2 inch out from the end of the toe and was in need of trimming. The resident's left great toenail had a similar appearance but was approximately 1/4 inch thick. The rest of the resident's toenails had a normal appearance and were only slightly in need of trimming. The toes and feet of the right foot were tinted reddish brown from the dried betadine ordered. The resident stated he needed them all trimmed and it had been too long but he was unable to answer how long. The resident was unable to answer all questions appropriately. In an interview on 9/25/24 at 10:28 a.m. Resident #52's RP (Responsible Party) stated the resident had thick long toenails, and he was not happy about it because the facility told him they have podiatry visits monthly and he had been asking for the resident to have his nail care done since January 2024 and he kept getting told the resident had been put on the podiatry list but still had not seen one. The RP stated the resident used to live with him and he used to cut his nails at home when he was living with him and has trimmed his nails at the facility once so far because he felt he could not wait any longer but the resident really needed a professional like a podiatrist to trim his great toenails. The RP was unsure of which staff members have told him that the resident had been put on the podiatry list but it was multiple nurses and the RP had discussed it with previous SW as well. In an observation and interview on 9/27/24 at 3:20 p.m. the DON stated she was unsure why Resident #52 had not been seen by a podiatrist. The DON was looked on the computer and was unable to locate podiatry visit records or notes. The DON stated it would be important for the resident to see a podiatrist especially with his arterial wounds to his toes. The DON stated without treatment the toenails could continue thickening or growing back over into the skin and could cause an infection. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42031 Based on observation, interview, and record review the facility failed to ensure a resident received appropriate treatment and services to prevent urinary tract infections for 1 of 4 residents (Resident #94), reviewed for quality of care. Resident #94's catheter care was not provided according to facility policy or standards of care. This failure could place resident's at risk of pain, anxiety, and could result in infection, illness, and a general decline in health. The findings were: Record review of Resident #94's face sheet dated 9/27/24 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included retention of urine (a condition in which you are unable to empty all the urine from your bladder), hydronephrosis (a condition where one or both kidneys become stretched and swollen as the result of a build-up of urine inside them), obstructive uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional), and Vascular dementia (refers to changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain). Record review of Resident #94's quarterly MDS assessment dated [DATE] revealed the resident usually understands and was usually understood by others, had a BIMS score of 12 of 15 indicating the resident was moderately cognitively impaired. The resident used a wheelchair and had an indwelling catheter and was frequently incontinent of bowel. Section J0200 indicated the pain assessment interview should not be conducted due to the resident never or rarely being understood and the staff assessment for pain indicated the resident had no indicators of pain. Record review of Resident #94's Physician orders revealed an order with a start date of 4/30/24 for Foley Catheter Care: provide catheter care every shift and as needed every shift. In an observation on 9/27/24 at 11:25 a.m. CNA E provided catheter care for Resident #94, assisted by CNA F and CNA H. CNA E using a warm water basin with soap in a bottle on the side of the basin. Resident #94 stated he hurts where the catheter enters and staff stated they would notify the nurse. CNA E wet a washcloth and applied soap to the washcloth then immediately grabbed the catheter at the urinary meatus with his left hand and took the soapy washcloth with his right hand and wrapped a portion around the catheter tubing starting at the urinary meatus and wiped all the way to wear the catheter connected to the drainage tubing, turned the washcloth and did the same thing again, CNA E repeated this process 4 times. He then disposed of the washcloth, and gloves, sanitized his hands and donned new gloves. He got a new washcloth with plain warm water and proceeded to do the same procedure for rinsing. The CNA's assisting him then coached him slightly and he sanitized his hands and donned new gloves and a warm wet washcloth with soap and cleaned the residents groin area on both sides. At no time during his catheter care was the urinary meatus or surrounding area cleaned. During the catheter care the resident gasped twice and stated he hurts down there and was sensitive. There were no issues with hand sanitizing, glove usage, or EBP. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/27/24 at 11:45 a.m. CNA F and CNA H stated they usually do clean the urinary meatus first prior to the catheter and were unsure of why that was not completed but should have been. CNA E then joined the interview and CNA F and CNA H explained we were discussing cleaning the urinary meatus and surrounding area during catheter care and CNA E stated okay. In an interview on 9/27/24 at 3:20 p.m. the DON stated the staff should have cleaned the area during catheter care per the facility policy to prevent cross contamination and infection and she was unsure why it was not and the staff were trained on catheter care. Review of CNA E's competency validation for care of an indwelling catheter dated 8/27/24 revealed CNA E passed and had met all of the critical elements including . 8. Washes perineal area with no rinse perineal cleanser and pats area dry. B. Male- washes area around catheter insertion site and then from tip of the penis down to the body. Includes the scrotum and the skin folds around and underneath the scrotum. 9. Cleanses the proximal (nearer to the center or trunk of the body or to the point of attachment to the body) third of the catheter with soap and water, washing away from the insertion site . Review of the facility policy on urinary catheter care revised September 2014 indicated the steps in the procedure . 7. Wash the resident's genitalia and perineum thoroughly with soap and water. Rinse the area well and towel dry.16. For a male resident: Use a washcloth with warm water and soap to cleanse around the meatus. Cleanse the glans using circular strokes from the meatus outward . 17. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from the insertion site to approximately 4 inches outward.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42031 Based on observation, interview, and record review the facility failed to ensure a resident who needed respiratory care, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 1 of 3 residents (Resident #79), reviewed for quality of care. Resident #79's oxygen nasal cannula was on the floor and not covered or protected from the elements. This failure could result in cross contamination and could result in infection, and illness. The findings were: Record review of Resident #79's face sheet dated 9/27/24 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with readmission on 5/4/24. Her diagnoses included cerebral infarction (also known as a stroke-refers to damage to tissues in the brain due to a loss of oxygen to the area), acute cough, and wheezing. Record review of Resident #79's annual MDS assessment dated [DATE] indicated the resident had clear speech, understood other and able to make herself understood, had a BIMS score of 14 of 15 indicating the resident was cognitively intact. The resident had shortness of breath or trouble breathing with exertion (walking, transferring, bathing etc.) and when lying flat and the resident was on oxygen. Record review of Resident #79's care plan last reviewed on 8/18/24 revealed no focus or problems relating to the resident receiving oxygen. Record review of Resident #79's Physician's orders revealed an order with a start date of 5/7/24 for Oxygen at 2 liters per minute via nasal cannula, or as needed for shortness of breath as needed. Record review of Resident #79's Physician's orders revealed an order with an order date of 7/9/24 for referral to Pulmonologist for a mass in lung for evaluation and treatment. (an appointment was scheduled for 10/9/24). In an observation on 9/24/24 at 10:28 a.m. Resident #79 was being assisted by staff leaving her room in her wheelchair. The resident had on a nasal cannula and portable oxygen. In Resident #79's room her oxygen concentrator was against the far wall by the window and her oxygen tubing and nasal cannula were on the floor with the nasal prongs touching the floor. In an observation and interview on 9/24/24 at 10:30 a.m. LVN I stated the resident wears oxygen at 2 liters per minute and stated the nasal cannula and tubing should not be on the floor and was usually in a bag when the resident was on her portable oxygen. LVN I stated therapy just came and got the resident and she was unsure of why the tubing was not placed in a bag properly. LVN I then disconnected the tubing from the oxygen concentrator and picked up the oxygen tubing and nasal cannula and disposed of them in the trash. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 9/27/24 at 3:20 p.m. the DON stated the oxygen tubing should be in a respiratory bag when not in use and being on the floor could cause infection. Review of the facility policy on respiratory therapy for preventing infection revised November 2011 indicated . 8. Keep the oxygen cannulae and tubing used PRN (as needed) in a plastic bag when note in use.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review revealed the facility failed to ensure correct use of bed rails including but not limited to the following elements. Assess the resident for risk of entrapment from bed rails prior to installation and obtain informed consent prior to installation for 2 of 6 Residents (Resident #71 and Resident #160) whose records were reviewed. 1. Nursing staff failed to obtain an informed consent for the use of 1/4 bed rails for Resident #71. 2. Nursing staff failed to designate the reason for the use of the 1/4 bed rails on the bed evaluation for Resident #160 and failed to obtain an informed consent for the use the bed rails. These deficient practices could affect residents who used bed rails and could result residents not having required documentation in place for the use of bed rails. The findings were: 1. Review of Resident #71's face sheet, dated 9/27/24, revealed she was admitted to the facility on [DATE] with diagnosis including Dementia, Schizoaffective Disorder and Major Depressive Disorder, all dated 4/17/23. Review of Resident #71's quarterly MDS assessment, dated 7/25/24, revealed her BIMS was 0 meaning she was unable to complete the Brief Interview for Mental Status. Further review revealed Resident #71 was able to roll from side to side and sit up in bed independently. Review of Resident #71's Care Plan, revised 4/24/23, revealed, The resident is at risk for limited physical mobility r/t lack of coordination, generalized weakness, muscle wasting and atrophy, Muscle weakness and May utilize 1/4 side rail on bilateral sides of bed as mobility enabler. Review of Resident #71's Bed Rail Evaluation dated, 7/19/24, revealed the bed rails were used as enablers. Review of Resident #71's EHR/miscellaneous section revealed there was not a consent for the use of bed rails Observation on 09/24/24 at 10:46 AM revealed Resident #71's bed had two 1/4 bed rails up. Attempted interview with Resident #71 revealed she did not engage in conversation; was not interviewable. Interview on 09/27/24 at 04:13 PM with MDS Coordinator and the DON revealed when Resident's used bed rails as enablers staff should ensure they completed an evaluation, obtain a consent, a physician's order and the use of the bed rails should be implemented into the CP. The MDS Coordinator and the DON stated staff did not have a family representative sign a consent for the use of side rails; therefore, technically Resident #71 could not sue them until one was obtained. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #160's face sheet, dated 9/27/24, revealed she was admitted to the facility on [DATE] with diagnoses including Other Malaise. Further review revealed Resident #160 had been in the facility 9 days. Review of Resident #160's EHR revealed an MDS had not been completed because it was not due until day 14 per RAI. Review of Resident #160's Baseline Care Plan, dated 9/18/24, revealed she was cognitively intact. Further review revealed under section H., Resident #160 did not use any safety devices. Review of Resident #160's Bed Rail Evaluation, dated 9/18/24, revealed bed rails are indicated and serve as an enabler. Review of Resident #160's Bed Rail Consent, dated 9/18/24, revealed it was signed. However, the signer did not check off in the check box confirming the use of side rail. Observation on 09/24/24 at 10:04 AM revealed Resident #160 was lying in bed with two 1/4 side rail's up. Observation on 09/26/24 at 9:55 AM revealed Resident #160 sitting in a recliner with oxygen infusing at 2L. Further observation revealed two side rails were up on the bed. Interview with Resident #160 stated she asked for the use of side rails upon admission because she was very weak. She stated they helped her for bed mobility and to assist in sitting up in bed to prepare for transfers out of bed. Interview on 09/27/24 at 04:13 PM with the MDS Coordinator and the DON revealed when Resident's used bed rails as enables staff should ensure they completed an evaluation, obtain a consent, a physician's order and the use of the bed rails should be implemented into CP. The MDS Coordinator and the DON stated all of these components were not completed for Resident #160. Review of facility policy, Proper Use of Side Rails revised December 2016 read: The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms. General Guidelines 2. Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents. 3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: a. Bed mobility; b. Ability to change positions, transfer to and from bed or chair, and to stand and toilet; c. Risk of entrapment from the use of side rails; and d. That the bed's dimensions are appropriate for the resident's size and weight. 4. The use of side rails as an assistive device will be addressed in the resident care plan. 5. Consent for using restrictive devices will be obtained from the resident or legal representative per facility protocol.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46677 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for 1 of 1 kitchen observed for food service. The facility failed to ensure that items stored in the walk-in in refrigerator were labeled. The Dietary Manager and Dietary Aide failed to wear beard restraints while working in the kitchen. Cook and Dietary Aide did not properly wear hair restraints in a way that covered all their hair. This failure could place residents who receive food prepared in the facility's only kitchen by placing them at risk for food-borne illness and food contamination. The findings were: Observation of the facility's kitchen on [DATE] at 8:40 AM revealed Dietary Manager not wearing beard restraint over his facial hair while in the kitchen. Observation of the walk-in refrigerator on [DATE] at 8:44 AM revealed 13 trays of pre-portioned drinks, cakes, and bowls of cereal and unlabeled. Observation of the facility kitchen on [DATE] at 10:24 AM revealed Cook's hair restraint not covering all her hair while preparing pureed foods for lunch. Further observation revealed the Dietary Aide's hair restraint not covering all his hair while doing dishes. Interview with [NAME] on [DATE] at 10:52 AM revealed the [NAME] received training from the dietary manager on appropriate hygiene when first hired. The [NAME] stated hair restraints are to cover all hair to prevent hair from falling into food. The [NAME] stated that hair falling into food could cause foodborne illness in the residents. The [NAME] stated all open food in the walk-in refrigerator needed to be labeled with the date open. The [NAME] also stated that it was the responsibility of whoever was putting open items in the walk-in to label it. Interview with Dietary Aide on [DATE] at 10:54 AM revealed he had worked at the facility since January of 2024 and received training on appropriate hygiene when he started. The Dietary Aide stated hair restraints should cover all hair on top the head. Dietary Aide stated any hair not in the hair restraint could fall into the food and cause foodborne illness in those who ate food from the kitchen. Dietary Aide stated food stored in the walk-in refrigerator was to be labeled with the date opened. Dietary Aide stated any staff placing open items in the walk-in refrigerator was responsible to label it. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Dietary Manager on [DATE] at 10:58 AM revealed staff are trained on appropriate hygiene when they start and all hair, including facial hair, was to be in a hair restraint when in the kitchen. Dietary manager stated hair that was not in a hair restraint could fall into food being prepared causing it to be contaminated. Dietary Manager stated contaminated food could cause foodborne illness in the residents. Dietary Manager stated all staff are responsible for labeling open items being placed in the walk-in refrigerator. Dietary Manager stated he checks the walk-in daily before the end of his shift to ensure all items are labeled. Dietary manager stated by not labeling items in the walk-in refrigerator there is potential to serve expired foods to residents causing foodborne illness. Record review of the facility policy named Preventing Foodborne Illness-Employee Hygiene and Sanitary Practice, not dated, revealed 11. Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens. Record review of the facility policy named Receiving, not dated, revealed 6. All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022 states Except as provided in, (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed ,d+[DATE].17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) -(G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 42031 Based on observations, interviews, and record reviews, 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 diseases and infections for 2 of 5 residents (Residents #69, #90) and 1 of 1 rooms (room [ROOM NUMBER]), reviewed for infection control. 1. Resident #69 was provided wound care without EBP being used 2. Resident #90 was provided wound care from supplies that were open and kept in the same baggie, the staff made direct contact with the and gloves were not changed after, and the padding in the soiled brief contacted the wound when applying the dressing, and after the wound care was completed, the wound dressing was covered with the soiled brief while turning the resident. 3. Nursing staff failed to ensure the shower chair in room [ROOM NUMBER] was cleaned and sanitized when soiled with feces. These failures could place residents at risk of cross contamination, infection, and illness. The findings were: 1. Record review of Resident #69's face sheet dated 9/27/24 revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with readmission on 10/14/22. Her diagnoses included Parkinson's disease (brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), and muscle wasting, and atrophy not elsewhere classified multiple sites (wasting or loss of muscle tissue). Record review of Resident #69's quarterly MDS assessment dated [DATE] indicated the resident rarely or never understands or was understood and had a BIMS score of 0 indicating the resident was severely cognitively impaired. The resident required Substantial/maximal assistance or was dependent for mobility. The resident was always incontinent of bowel and bladder and had no wounds. Record review of Resident #69's care plan last reviewed 7/19/24 revealed a focus initiated on 9/2/24 and revised on 9/18/24 for pressure ulcer to coccyx that was unstageable. Interventions included to administer treatments as ordered and to follow facility policies/protocols for the treatment of skin breakdown. Record review of Resident #69's Physician's orders revealed an order with a start date of 1/4/23 for hospice services. Record review of Resident #69's Physician's orders revealed an order with a start date of 9/18/24 for Coccyx Unstageable Pressure Injury: cleanse with NS (Normal Saline) or wound cleanser, pat dry with 4x4 gauze, apply (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medi honey and calcium alginate, and cover with bordered foam dressing daily and PRN every day shift for wound care. In an observation on 9/27/24 at 9:50 a.m. Resident #69 was provided wound care by RN C and was assisted by ADON D. An EBP (Enhanced Barrier Precautions) sign was on the resident's room door. RN C and ADON D completed the resident's wound care as ordered but did not utilize EBP by using PPE (Personal Protective Equipment) during the wound care. In an interview on 9/27/24 at 10:00 a.m. RN C and ADON D stated PPE for EBP should have been utilized. RN C stated not using EBP could cause cross contamination and infection control issues. 2. Record review of Resident # 90's face sheet dated 9/27/24 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included paraplegia (Severe or complete loss of motor function in the lower extremities and lower portions of the trunk), and pressure ulcer of the sacral region unspecified stage (pressure ulcer is a localized injury to the skin or underlying tissue, usually over a bony prominence, as a result of unrelieved pressure). Record review of Resident # 90's quarterly MDS assessment dated [DATE] indicated the resident had a BIMS score of 15 of 15 indicating the resident was cognitively intact. The resident had one stage 4 pressure ulcer. Record review of Resident # 90's care plan last reviewed on 7/30/24 revealed a focus revised on 1/2/24 for multiple pressure ulcers with a goal revised on 7/30/24 to be free from infection with a target date of 10/25/24. Interventions included to administer treatments as ordered. Record review of Resident # 90's Physician orders revealed an order with a start date of 8/29/24 for Left lateral buttocks stage 4 pressure injury: cleanse wound with NS, pat dry with 4x4 gauze, apply Santyl to wound bed, and calcium alginate, apply zinc to peri wound, and cover with bordered dressing daily and PRN. The wound care orders were for the Coccyx wound. In an observation on 9/27/24 at 9:10 a.m. RN C was prepping her supplies wound care and pulled a plastic baggie out of the treatment cart. Inside the plastic zip-loc bag was: * calcium alginate that was open and had been cut in to smaller pieces, *A previously opened and used tube of Santyl ointment inside the original box, and *a tube of zinc oxide ointment that had previously been opened. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN C pulled the items out one at a time with her bare hands and placed them back in the baggie when she was finished dispensing a certain amount of the ointments into clear plastic medicine cups. Further observation revealed during the wound care to the Resident #90's sacral region, RN C pushed the calcium alginate in and around the wound with her gloved finger then without changing gloves put her finger in the zinc oxide ointment and applied it around the wound edge. The smaller dressing to buttock was applied and overlapped the sacral wound slightly and did not stick due to the tape being applied over the zinc oxide. There was a pad inside a brief and the pad was slightly under the sacral dressing when applied and RN C had to pull the brief down slightly to free the brief. The pad inside the brief was observed to be slightly damp with urine and the resident wanted to turn prior changing his brief. The nurse then covered the dressings with the damp brief and pad and the resident and was then changed. In an interview on 9/27/24 at 9:35 a.m. RN C stated she should have changed gloves after putting her finger in the wound and prior to putting her glove inside the plastic cup. RN C stated the resident wanted to keep his brief and pad on and turn then staff could provide incontinent care. RN C stated the issues with wound care observations could cause infection control and cross contamination. In an interview on 9/27/24 at 3:20 p.m. the DON stated EBP should have been used for wound care and not using EBP could cause infection by way of cross contamination. The DON further stated the calcium alginate and creams should be in separate bags to prevent cross contamination, the soiled brief should have been changed prior to wound care and or not replaced over the clean wound dressings. 3. Observation on 09/24/24 at 10:41 AM in room [ROOM NUMBER] in the memory care unit revealed a shower chair beside the sink. There was dried brown substance on the seat. Observation and interview on 09/24/24 at 10:50 AM with LVN A revealed she walked in to the room and stated she was making sure no one was in the room. LVN A looked at the shower chair and stated the brown substance was BM, bowel movement. She stated the CNAs should be wiping down, cleaning the resident's equipment; shower chair after each shower, with disinfectant wipes. Interview on 9/27/24 at 12:08 PM with LVN A revealed both Residents in room [ROOM NUMBER] were cognitively impaired; anxious, would become easily agitated and wandered. She stated it was important for nursing staff to keep resident equipment clean to maintain good sanitation and infection control. LVN A stated she made rounds throughout the shift; however, on 09/24/2024, she did not go into the bathroom in room [ROOM NUMBER]. Review of the facility policy for wound care revised October 2010 indicated . The following equipment and supplies will be necessary when performing this procedure. 4. Personal protective equipment (eg., gowns, gloves, mask, etc., as needed).		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42031 Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program so that the facility is free of pests for 1 of 1 facility reviewed for physical environment. Multiple gnats were observed on resident food containers and flying around the facility. This failure places residents at risk of frustration, anxiety, and could result in the resident's not having a safe, sanitary environment. The findings were: In an observation of room [ROOM NUMBER] A on 9/24/24 at 9:45 a.m. on a bedside table next to bed held a tumbler and on top of the tumbler was a small snack sized Styrofoam bowl of fruit, possibly diced pears or peaches sealed with plastic wrap. On top of the plastic wrap was 8 to 10 gnats, and multiple flying around the tumbler and around surveyor's head at doorway. There was no loose food or open containers were observed. In an observation of room [ROOM NUMBER] A on 9/24/24 at 9:25 a.m. revealed a sticky fly trap tape hanging from the light above the bed on each side of the bed hanging down approximately 2.5 feet on each side. Approximately 7 gnats/fruit flies observed stuck to each tape. In an observation on 9/27/24 at 9:10 a.m. gnats were flying near a wound care treatment cart on 100 hall as the nurse was preparing supplies. In a group resident council meeting during the survey, the residents stated there was a pest control problem at the facility to include gnats and roaches. In an interview on 9/27/24 at 10:15 a.m. a resident expressed concerns about roaches, gnats, and flies in his room periodically throughout his stay at the facility. The resident stated he had seen the exterminator one time and the pest control man was not intending on spraying his room until the resident intervened. The resident stated he had told the previous SW and the Administrator but continued to have problems about the following areas: roaches, gnats and flies in his room periodically throughout his stay at the NF. In an interview on 9/27/24 at 3:10 p.m. the DON stated there was a gnat problem at times and the pest control comes. In an interview on 9/27/24 at 3:45 p.m. the Administrator stated pest control has treated for gnats and treats regularly. The Administrator stated that some residents hoard food and leftovers in their rooms and even in drawers but the facility continues to encourage the residents not to hoard food and leftovers in their rooms. He further stated that a resident had complained about gnats today and he had already contacted the pest control company and they will be coming to treat his room. Review of facility pest prevention service reports are as follows: (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: 676328	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Las Colinas of Westover		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*7 /26/24 room [ROOM NUMBER] for drain flies in bathroom, *8/5/24 inspected and treated all common areas and rooms 215, and 212. Target pests roaches, ants, crickets, and rodent, *8/30/24 inspected and treated all common areas and rooms 101, 110, 310, 200 for target pests ants, wasps, roaches, crickets, *9/3/24 all common areas and target pests roaches and rodent, and *9/19/24 all common areas and room [ROOM NUMBER]. Review of facility pest control service log indicated the facility had pest control visits on the following dates: * 7/26/24 for gnats, *8/5/24 for roaches and general pests, *8/21/24 general and roaches in 100, 200, 300. * 8/27/24, general pests. *8/30/24 general pests. *9/3/24 general pests, and *9/19/24 general pests. Review of facility pest control policy revised August 2008 indicated Our facility shall maintain an effective pest control program. 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.		