

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 12/03/2025
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to accurately reflect the residents' status for 4 residents (Residents #43, # 62, 75 and #106) of 32 residents reviewed for MDS assessments. Resident #43's quarterly MDS assessment dated [DATE] inaccurately reflected that she took an anticoagulant and did not reflect that she took an antiplatelet medication. 2. Resident #62's psychoactive and antiplatelet medications were not reflected on her quarterly MDS assessment dated [DATE]. 3. Resident #75's fall on 05/22/2025 was not reflected on her annual MDS assessment dated [DATE]. 4. The facility failed to ensure Resident #106's planned discharge was coded accurately. These facility failures affect residents who receive care and could result in missed or inappropriate care. The findings included: 1. Record review of Resident #43's electronic face sheet dated 09/30/2025 reflected she was a [AGE] year-old female who was readmitted to the facility on [DATE]. Her diagnoses included: chronic obstructive pulmonary disease (a group of lung diseases that cause ongoing inflammation and narrowing of the airways, making it difficult to breathe), type II diabetes mellitus (chronic condition where the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels), dysphagia (difficulty or discomfort in swallowing), dementia (condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), depression (common mental health condition characterized by persistent feelings of sadness hopelessness, and loss of interest or pleasure in activities), and cognitive communication deficit (condition that affects the brain's ability to perform mental processes, such as attention, memory, reasoning and problem-solving, which impairs ability to communicate effectively). Record review of Resident #43's Active Orders as of: 09/30/2025 reflected she was not ordered an anticoagulant (prevents the liver from producing vitamin K-dependent clotting factors). She had ordered Aspirin on 02/24/2025, which was classified as an antiplatelet (medication that prevented platelets from sticking together and forming blood clots). Record review of Resident #43's quarterly MDS assessment with an ARD of 09/12/2025 reflected she sometimes understood and could sometimes understand. She scored a 00 of 15 on her BIMS which indicated her cognitive status was severely impaired. She was dependent on most of her ADLs. Her MDS assessment reflected she took an anticoagulant and did not reflect that she took an antiplatelet. Record review of Resident #43's comprehensive care plan dated 02/26/2025 did not reflect that she took an anticoagulant or an antiplatelet . 2. Record review of Resident #62's electronic face sheet dated 09/30/2025 reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: chronic obstructive pulmonary disease (a group of lung diseases that cause ongoing inflammation and narrowing of the airways, making it difficult to breathe), dementia (condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), type II diabetes mellitus (chronic condition where the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels), major depressive disorder (common mental health condition characterized by persistent feelings of sadness, (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hopelessness, and loss of interest or pleasure in activities) and bipolar disorder (chronic mental health condition characterized by extreme mood swings between mania (high energy, euphoria, and impulsivity), hypothyroidism (when the thyroid gland does not make and release enough hormone into the bloodstream which can cause fatigue and weight gain) and depression (low mood, fatigue, and hopelessness). Record review of Resident #62's comprehensive care plan dated 09/21/2025 did not reflect that she took an antiplatelet. Resident #62's care plan dated 06/02/2025 reflected Focus, resident has an alteration in neurological status r/t bipolar disorder, Interventions: assess for effects of psychotropic meds, and give medications as ordered. Record review of Resident #62's quarterly MDS assessment with an ARD of 09/24/2025 reflected she usually understood and could usually understand. She scored an 8 of 15 on her BIMS which signified her cognitive status was moderately impaired. She required substantial assistance with most of her ADLs. She was not coded for taking an antipsychotic. Review of the section N040 Antipsychotic Medication Review, did the resident receive antipsychotic medications since admission/entry or reentry or prior OBRA assessment, whichever is more recent? 0 which indicated No was coded. The antiplatelet was not check marked. Record review of Resident #62's Active Orders as of: 09/30/2025 reflected she took Risperidone (antipsychotic medication) one tablet twice a day for antipsychotic purposes since 05/21/2025. Resident #62's orders reflected she took Aspirin EC Low Dose 81 mg, one tablet po each day since 05/23/2025. 3. Record review of Resident #75's electronic face sheet dated 09/30/2025 reflected she was an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: Alzheimer's disease (progressive brain disorder that causes memory loss, confusion, and other cognitive decline), dysphagia (difficulty swallowing foods and liquids), anxiety disorder (mental health condition characterized by excessive worry, fear, and nervousness that can interfere with daily life) , repeated falls (two or more falls occurring within a specific timeframe, most commonly defined as a 12-month period but sometimes also using a 6-month period), dementia (general term for a group of brain disorders that cause a progressive decline in cognitive abilities, such as: memory, thinking, language, judgment, problem-solving, and behavior), bipolar disorder (a chronic mental health condition characterized by extreme mood swings between periods of mania (elevated mood) and depression) and psychosis (mental health condition characterized by a loss of touch with reality). Record review of Resident #75's incident report dated 06/11/2025 reflected she had a fall and was found lying on the fall mat on the floor.' Record review of Resident #75's annual MDS assessment with an ARD of 08/21/2025 reflected she was usually understood and sometimes understands. She scored 3 of 15 on her BIMS which indicated her cognitive status was severely impaired. She was dependent on her ADLs. Review of section J1800 Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), reflected a 0 which indicated No. Her previous quarterly MDS assessment was completed on 05/22/2025. Record review of Resident #75's comprehensive care plan dated 06/11/2025 reflected Focus, resident is high risk for falls r/t resident has no safety awareness, 06/11/2025-Found sitting on fall mat in room, Interventions, bed in lowest position, fall mats on floor. During an interview on 10/03/2025 at 07:41 am with LVN E revealed she had miscoded Resident #45's quarterly MDS assessment because aspirin was not considered an anticoagulant. She stated she should have checked off antiplatelet. She stated that an inaccurate MDS assessment did not reflect the residents and could affect the care of the residents with misinformation. She stated she did not know why she coded Resident #43's MDS to show she took an anticoagulant and did not code antiplatelet. She stated Resident #62's quarterly MDS dated [DATE] did not reflect she took an antipsychotic medication or an antiplatelet when she took Risperidone and Aspirin daily. LVN E stated Resident #62's fall in on 06/11/2025 was between assessment periods and her annual MDS assessment dated [DATE] should have reflected the fall. During an interview on 10/03/2025 at 08:56 am, the DON stated it was important to have the correct information to accurately reflect the resident's condition on the MDS. She stated care could be missed or the residents might receive inappropriate care because the MDS information was transferred to the comprehensive care plan. She (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated Resident #43 was prescribed an antiplatelet and not an anticoagulant and that it needed to be coded accurately on the MDS and care planned because the two medications worked differently. She stated Resident #62's Risperidone and Aspirin needed to be coded on her MDS and Resident #75's fall needed to be reflected. During an interview on 10/03/2025 at 09:30 am, the ADM stated the MDS was important, and he was accountable for some of the MDS. He stated the information from the MDS assessments is transferred to the care plan and if the MDS was inaccurate, the care plan could be, and care could be missed for a resident. 4. Record review of Resident #106's face sheet dated 10/01/2025, revealed Resident #25 was admitted to the facility on [DATE], readmitted on [DATE] with diagnoses that included: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, hypertension (high blood pressure), hypothyroidism (thyroid gland doesn't make and release enough hormone into the bloodstream), and atherosclerotic heart disease of native coronary artery without angina pectoris (heart tissue isn't receiving enough oxygen-rich blood due to narrowed or blocked arteries). Record review of Resident #106's progress note revealed a progress note dated 07/26/2025 that reflected [ambulance company name] here to pick up resident and take her home, belongings/medications signed by EMS driver, all belongings taken with resident, resident left facility by stretcher,. Resident #106's progress notes further revealed a note dated 07/17/2025 that reflected, Respite day 3/11. Resident will be private pay the 20th-25th. Patient adjusting well, good appetite with no signs of pain or distress this shift. Record review of Resident #106's physician order summary dated, 10/01/2025, reflected admit to respite for care giver relief for 5 days from 07/15/25 - 07/20/25, will remain at [facility name] from 07/20/25 - 07/25/25 private pay. Record review of Resident #106's Discharge MDS assessment, dated 07/26/2025 revealed Section A0310 F of discharge assessment - return not anticipated. Section A0310 G further revealed the type of discharge code as a 2 for unplanned. During an interview on 10/01/2025 at 3:34 p.m. the MDS coordinator stated the Discharge MDS Assessment was miscoded, and it was just an error. The MDS coordinator further stated the Discharge MDS assessment should have been coded 1 for planned discharge after having reviewed Resident #106's orders and electronic medical record. The MDS coordinator stated she was responsible for the coding of the MDS and for the accuracy of the MDS assessments. During an interview on 10/03/2025 at 1:55 p.m. the ADM stated the MDS coordinator was responsible for the MDS assessment accuracy and there was an offsite consultant that also oversaw the MDS coordinator. The ADM stated by miscoding MDS assessment could have caused issues with the payment of a resident's care. Record review of the CMS RAI Version MDS 3.0 Manual dated October 2025 revealed in part, .The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each resident. Section A: Identification Information Intent: The intent of this section is to obtain the reasons for assessment, administrative information, and key demographic information to uniquely identify each resident.Coding instructions for A0310G, type of discharge (complete only if A030F =10 or 11). Enter the number corresponding to the type of discharge. Code 1: if type of discharge is a planned discharge. Code 2: if type of discharge is an unplanned discharge. Record review of the facility policy and procedure titled Resident Assessment Instrument (undated) reflected The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity, information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning. Record review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1, October 2025 reflected The RAI process has multiple regulatory requirements . (1) the assessment accurately reflects the resident's status.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observations, interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 3 residents (Resident #37, #62 and #75) of 32 residents reviewed for care plans. 1. Resident #37's comprehensive care plan did not reflect that she required a leg strap to hold her indwelling catheter tubing in place. 2. Resident #62's comprehensive care plan did not reflect she had hypothyroidism as an active diagnosis or her use of an antiplatelet medication. 3. Resident 75's comprehensive care plan did not reflect that she had electronic monitoring in her room. This facility failure affects residents at the facility and could result in missed or inaccurate care provided. Findings included: 1. Record review of Resident #37's electronic face sheet dated 10/02/2025 reflected she was a [AGE] year-old female who was readmitted to the facility on [DATE]. Her diagnoses included fracture of unspecified part of neck of left femur (a break in the neck of the thigh bone), chronic obstructive pulmonary disease (lung disease characterized by ongoing inflammation and narrowing of the airways, leading to airflow obstruction and breathing difficulties), permanent atrial fibrillation (condition where the heart's upper chambers beat irregularly and rapidly for an extended period, and it is not possible to restore a normal heart rhythm through treatment), and retention of urine (inability to empty the bladder completely). Record review of Resident #37's annual MDS assessment with an ARD of 07/24/2025 reflected that she could understand and be understood. She scored a 10 of 15 on her BIMS which indicated her cognitive status was moderately impaired. She had an indwelling urinary catheter. She required partial assistance with her ADLs. Record review of Resident #37's Active Orders as of: 10/02/2025 reflected Foley leg strap/tubing: secure tubing with leg strap in place at all times to prevent pulling, start date 08/14/2024. Record review of Resident #37's comprehensive care plan dated 04/04/2025 reflected Focus, has an indwelling catheter, interventions, check tubing for kinks each shift. Resident #37's need for a urinary catheter leg strap was not reflected. 2. Record review of Resident #62's electronic face sheet dated 09/30/2025 reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: chronic obstructive pulmonary disease (a group of lung diseases that cause ongoing inflammation and narrowing of the airways, making it difficult to breathe), dementia (condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), type II diabetes mellitus (chronic condition where the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels), major depressive disorder (common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities) and bipolar disorder (chronic mental health condition characterized by extreme mood swings between mania (high energy, euphoria, and impulsivity), hypothyroidism (when the thyroid gland does not make and release enough hormone into the bloodstream which can cause fatigue and weight gain) and depression (low mood, fatigue, and hopelessness). Record review of Resident #62's quarterly MDS assessment with an ARD of 09/24/2025 reflected she usually understood and could usually understand. She scored an 8 of 15 on her BIMS which signified her cognitive status was moderately impaired. She required substantial assistance with most of her ADLs. She was coded to have an active diagnosis of hypothyroidism. Record review of Resident #62's Active Orders as of: 09/30/2025 reflected she took Levothyroxine Sodium, one tablet each day for hypothyroidism since 05/21/2025. Resident #62's orders reflected she took Aspirin EC Low Dose 81 mg, one tablet po each day since 05/23/2025. Record review of Resident #62's comprehensive care plan dated 09/21/2025 did not reflect she was treated for (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hypothyroidism, or she took an antiplatelet. 3. Record review of Resident #75's electronic face sheet dated 09/30/2025 reflected she was an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: Alzheimer's disease (progressive brain disorder that causes memory loss, confusion, and other cognitive decline), dysphagia (difficulty swallowing foods and liquids), anxiety disorder (mental health condition characterized by excessive worry, fear, and nervousness that can interfere with daily life), repeated falls (two or more falls occurring within a specific timeframe, most commonly defined as a 12-month period but sometimes also using a 6-month period), dementia (general term for a group of brain disorders that cause a progressive decline in cognitive abilities, such as: memory, thinking, language, judgment, problem-solving, and behavior), bipolar disorder (a chronic mental health condition characterized by extreme mood swings between periods of mania (elevated mood) and depression) and psychosis (mental health condition characterized by a loss of touch with reality). Record review of Resident #75's annual MDS assessment with an ARD of 08/21/2025 reflected she was usually understood and sometimes understands. She scored 3 of 15 on her BIMS which indicated her cognitive status was severely impaired. She was dependent on her ADLs. Observation on 09/30/2025 at 09:40 am revealed signage on Resident #75's room which indicated Electronic Monitoring was used in the room. A camera could be seen in the room from the doorway which triggered with motion. Record review of a consent dated 07/05/2025 reflected Resident #75's family member who was her RP had consented to electronic monitoring. Record review of Resident #75's comprehensive care plan dated 06/11/2025 did not reflect that she had electronic monitoring in her room. During an interview on 10/03/2025 at 07:41 am with LVN E revealed that the care plan was part of the IDT development. She stated Resident #37's leg strap needed to be care planned because it was a specific part of her care. She stated Resident #62's antiplatelet, and hypothyroidism needed to be care planned and did not know how they were missed. She said the care plan tells others what care the resident required specific to that resident. She stated Resident #75's electronic monitoring was a preference which needed to be care planned to let others know her family wanted the monitoring in place to observe her care and condition and that was their right. During an interview on 10/03/2025 at 08:56 am, the DON stated it was important for the care plan to be accurate because it communicated to others the residents care requirements or preferences. She stated Resident #37's catheter leg strap needed to be care planned, Resident #62's hypothyroidism and antiplatelet, and Resident #45's electronic monitoring needed to be care planned because care could be missed without the information being transferred to the Kardex (care form for CNA's) about the resident. During an interview on 10/03/2025 at 09:30 am, the ADM stated information from the MDS assessments is transferred to the care plan and if the MDS was inaccurate, the care plan could be, and care could be missed for a resident. Record review of the facility policy and procedure titled Comprehensive Assessment and the Care Delivery Process (undated) reflected Comprehensive assessments, care planning and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions. Record review of the facility policy and procedure titled Care Plans, Comprehensive Person-Centered dated December 2016 reflected The IDT, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident, the comprehensive, person-centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and records reviews the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preference for 4 residents (Resident #35, Resident #43, Resident #45, and Resident #62) of 4 residents observed for oxygen therapy.1. The Facility failed to ensure Resident #35 had an order for the use of oxygen with the liters per minute to be used.2. Resident #43 was observed in the dining room with a portable oxygen tank set on 2L/min via NC and the pressure gauge needle was in the red zone (which indicated near empty or empty and requires immediate attention).3. Resident #62 was sitting in a common area prior to lunch near the 200 Hall nurses' station at a table with a portable oxygen tank set on 2L/min via NC and the pressure gauge needle was in the red zone.This facility failure affects residents who receive oxygen therapy and could result in hypoxia (low oxygen in blood) or respiratory distress.The findings included:1. Record review of Resident #35's face sheet, dated 10/01/2025, revealed Resident #35 was admitted on [DATE] with diagnoses which included: obesity, class 3 (a complex chronic disease in which you have a body mass index (BMI) of 40 or higher), pulmonary hypertension (high blood pressure that affects the arteries in the lungs and the right side of the heart), unspecified, (congestive) heart failure, pleural effusion (collection of fluid around your lungs), not elsewhere classified, and fluid overload, unspecified. Record review of Resident #35's admission assessment, dated 09/19/2025, revealed Resident #35's BIMS score was 14 noting intact cognition. The admission assessment further revealed Resident #35 receiving oxygen therapy while a resident. Record review of Resident #35's care plan with an initiated date of 09/21/2025, revealed Resident #35 had a Focus: The resident has Oxygen Therapy r/t ineffective gas exchange. Record review of Resident #35's physician's order summary report, dated 10/01/2025, revealed there were not any orders for Resident #35 to receive oxygen and did not have orders for number of liters per minute. Observation on 09/30/2025 at 10:02 a.m. revealed an EBP (Enhanced Barrier Precaution) sign to Resident #35's room door with supplies present outside of the room and an oxygen in use sign present. Resident #35 was observed to be lying in his bed wearing oxygen with it set at 2.5 liters. During interview and observation on 10/01/2025 at 3:09 p.m. Resident #35 stated he used his oxygen pretty much all the time and took a portable tank with him when going to dialysis. Resident #35 further stated his oxygen was usually set at 2 or 3 liters when using it. Resident #35 was observed wearing oxygen during the interview. During an interview and observation on 10/01/2025 at 3:25 p.m. LVN H stated Resident #35 preferred to wear his oxygen continuously. LVN H stated she believed Resident #35 was supposed to have his oxygen set at 3 liters. LVN H reviewed Resident #35's physician's orders and stated she did not see an order. LVN H stated there should have been an order for oxygen. LVN H stated usually the use of oxygen was verified by the physician when reviewing admission orders with them. LVN H further stated Resident #35 was alert and oriented times 4 and was able to tell her what his oxygen was supposed to be set at. LVN H stated they needed an order for everything. During an interview on 10/01/2025 at 3:41 p.m. the DON stated the use of oxygen once would have been considered a nursing judgment, but the nurse needed to put an order in. The DON stated orders informed the staff if the oxygen was to be used PRN or continuously, if the resident had respiratory problems and it would tell them how many liters were supposed to be used. The DON further stated the ADON would do chart audits and was not sure why Resident #35 did not have the lack of an order was not caught. The DON stated it was the nurse's responsibility to get the order for oxygen use and how much to give. The DON stated he came with an order for PRN oxygen use after having reviewed Resident #35's clinical records sent with him. During an interview on 10/03/2025 at 1:59 p.m. the ADM stated Resident #35 should have had orders for oxygen use due to having to have an order for any care provided. The ADM stated the nursing staff (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were responsible for ensuring orders were written. 2. Record review of Resident #43's electronic face sheet dated 09/30/2025 reflected she was a [AGE] year-old female who was readmitted to the facility on [DATE]. Her diagnoses included: chronic obstructive pulmonary disease (a group of lung diseases that cause ongoing inflammation and narrowing of the airways, making it difficult to breathe), type II diabetes mellitus (chronic condition where the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels), dysphagia (difficulty or discomfort in swallowing), dementia (condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), depression (common mental health condition characterized by persistent feelings of sadness hopelessness, and loss of interest or pleasure in activities), and cognitive communication deficit (condition that affects the brain's ability to perform mental processes, such as attention, memory, reasoning and problem-solving, which impairs ability to communicate effectively). Record review of Resident #43's quarterly MDS assessment with an ARD of 09/12/2025 reflected she sometimes understood and could sometimes understand. She scored a 00 of 15 on her BIMS which indicated her cognitive status was severely impaired. She was dependent on most of her ADLs. She received therapeutic oxygen while she was a resident. Record review of Resident #43's comprehensive care plan dated 03/18/2025 reflected Focus, has oxygen therapy, interventions, for residents who should be ambulatory, provide extension tubing or portable oxygen, if a resident is allowed to eat, oxygen still must be given to the resident. Record review of Resident #43's Active Orders as of: 09/01/2025 reflected Oxygen at 2-4 L/Min via NC, on continuous every shift for shortness of breath, start date 06/04/2025. Observation on 09/30/2025 at 11:40 pm of Resident #43 in the dining room sitting at a table waiting for lunch to be served revealed she had oxygen via a portable tank set at 2L/Min, and the pressure gauge was in the red zone. She did not appear in respiratory distress. Observation on 09/30/2025 at 12:15 pm with the DON revealed Resident #43 in the dining room and her portable oxygen tank gauge was in the red zone. She did not appear in respiratory distress or have signs of difficulty breathing. Interview on 10/01/2025 at 07:30 am, LVN A who was Resident #43's nurse on 09/30/2025, stated an E tank lasted about 4 hours and the pressure gauge should not get into the red zone because it indicated oxygen pressure was low or gone. She stated she was busy and did not think to check Resident #43's oxygen tank until the DON directed her to it. She stated Resident #43 had no signs of respiratory distress or shortness of breath. She stated she was trained to change out the portable oxygen tank when the pressure gauge was near or in the red zone. 3. Record review of Resident #62's electronic face sheet dated 09/30/2025 reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: chronic obstructive pulmonary disease (a group of lung diseases that cause ongoing inflammation and narrowing of the airways, making it difficult to breathe), dementia (condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), type II diabetes mellitus (chronic condition where the body does not use insulin effectively or does not produce enough insulin to regulate blood sugar levels), major depressive disorder (common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities) and bipolar disorder (chronic mental health condition characterized by extreme mood swings between mania (high energy, euphoria, and impulsivity), hypothyroidism (when the thyroid gland does not make and release enough hormone into the bloodstream which can cause fatigue and weight gain) and depression (low mood, fatigue, and hopelessness). Record review of Resident #62's quarterly MDS assessment with an ARD of 09/24/2025 reflected she usually understood and could usually understand. She scored an 8 of 15 on her BIMS which signified her cognitive status was moderately impaired. She required substantial assistance with most of her ADLs. She received therapeutic oxygen while a resident. Record review of Resident #62's comprehensive care plan dated 07/22/2025 reflected Focus, has oxygen therapy r/t (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Las Colinas of Westover		STREET ADDRESS, CITY, STATE, ZIP CODE 9738 Westover Hills Blvd San Antonio, TX 78251	
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	COPD, interventions, for residents who should be ambulatory, provide extension tubing or portable oxygen, if the resident is allowed to eat, oxygen still must be given. Observation on 09/30/2025 at 11:20 pm of Resident #62 sitting at a table near the nurses' station on 200 Hall revealed she had a portable oxygen tank set at 2L/Min via NC and her oxygen pressure gauge was in the red zone. She did not appear to be in respiratory distress. Observation on 09/30/2025 at 12:00 pm of Resident #62 with the DON revealed she was sitting at a table near the nurses' station on 200 Hall and had a portable oxygen tank and the oxygen pressure gauge was in the red zone. Interview at 10/01/2025 at 7:15 am, RN F who was Resident #62's nurse on 09/30/2025 stated Resident #62 got up out of bed at 07:00 am and he had equipped her with a full oxygen tank. He stated a portable oxygen E tank at 2L/Min last 4 hours and needed to be changed. He stated the tank gauge should not be in the red and he should have checked the tank and did not think about it. He stated he checked the resident, and she did not appear to be in respiratory distress or having difficulty breathing. He stated he felt air flow coming through the tubing when he changed the tank. He stated he was trained to change out a portable oxygen tank when the pressure indicator was low or near the red zone. During an interview on 10/03/2025 at 08:56 am, the DON stated she was accountable for the nursing care in the facility and the nurses needed to check the portable oxygen tanks. She stated the tank pressure gauges should never get into the red zone. She stated when a tank is near empty moisture can get into the tank due to the low pressure and can damage the integrity of the tank which can cause rust on the inside. She stated the oxygen pressure gauge needed to be checked frequently and nurses needed to make sure residents received their adequate oxygen flow to prevent respiratory distress. Record review of the facility's policy titled Safety and Supervision of Residents Oxygen, effective date, 11/28/2020, revealed Objective: To ensure sanitary, appropriate use and storage of oxygen cylinders for safety of all residents. Policy: Facility must ensure use of oxygen safely maintain or improve respiratory status by 1. ensuring complete physician order for device including administration rate and time. Record review of the facility's policy titled Oxygen Administration, revised date, November 2011, revealed Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration.		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on interview and record review, the facility failed to develop, implement, and maintain an effective training program for all new and existing staff for 19 of 24 (Administrator, DON, Dietary Manager, Activity Director, Social Worker, LVN G, LVN L, CNA M, CNA N, CNA O, Restorative Aide P, CNA Q, CNA R, CNA S, CNA T, RN U, RN V, LVN W, and ADON X) employees reviewed for training requirements. The facility failed to implement and maintain a training program that ensured Social Worker, Dietary Manager and Restorative Aide P received required trainings upon hire. The facility failed to implement and maintain a training program that ensured Administrator, DON, Activity Director, LVN G, LVN L, CNA M, CNA N, CNA O, CNA Q, CNA R, CNA S, CNA T, RN U, RN V, LVN W, and ADON X received required training annually. This failure could place residents at risk of being cared for by staff who have been insufficiently trained. The findings were: Record review of personnel record for Administrator revealed hire date of 02/08/2021. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the Administrator completed the required annual training. Record review of personnel record for DON revealed hire date of 11/21/2022. Review of training log for the previous 12 months provided by human resources revealed no evidence that DON completed the required annual training. Record review of personnel record for Dietary Manager revealed hire date of 09/02/2025. Review of the training log provided by human resources revealed the Dietary Manager did not complete the required training upon hire. Record review of personnel record for Activity Director revealed hire date of 01/05/2021. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the Activity Director completed the required annual training. Record review of personnel record for Social Worker revealed hire date of 09/02/2025. Review of training log provided by human resources revealed the Social Worker did not complete the required training upon hire. Record review of personnel record for LVN G revealed hire date of 02/10/2021. Review of the training log for the previous 12 months provided by human resources revealed no evidence that LVN G completed the required annual training. Record review of personnel record for LVN L revealed hire date of 06/24/2022. Review of the training log for the previous 12 months provided by human resources revealed no evidence that LVN L completed the required annual training. Record review of personnel record for CNA M revealed hire date of 08/02/2024. Review of the training log for the previous 12 months provided by human resources revealed no evidence that CNA M completed the required annual training. Record review of personnel record for CNA N revealed hire date of 12/20/2023. Review of training log for the previous 12 months provided by human resources revealed no evidence that CNA N completed the required annual training. Record review of personnel record for CNA O revealed hire date of 11/08/2023. Review of the training log for the previous 12 months provided by human resources revealed no evidence that CNA O completed the required annual training. Record review of personnel record for Restorative Aide P revealed hire date of 08/26/2025. Review of training log provided by human resources revealed Restorative Aide P did not complete the required training upon hire. Record review of personnel record for CNA Q revealed hire date of 01/23/2023. Review of the training log for the previous 12 months provided by human resources revealed no evidence that CNA Q completed the required annual training. Record review of personnel record for CNA R revealed hire date of 02/10/2021. Review of the training log for the previous 12 months provided by human resources revealed no evidence that CNA R completed the required annual training. Record review of personnel record for CNA S revealed hire date of 01/23/2022. Review of the training log for the previous 12 months provided by human resources revealed no evidence that CNA S completed the required annual training. Record review of personnel record for CNA T revealed hire date of 06/06/2024. Review of the training log for the previous 12 months provided by human resources revealed no evidence that CNA T completed the required annual training. Record review of personnel record for RN U revealed hire date of (continued on next page)		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/21/2022. Review of the training log for the previous 12 months provided by human resources revealed no evidence that RN U completed the required annual training. Record review of personnel record for RN V revealed hire date of 03/07/2024. Review of training log for the previous 12 months provided by human resources revealed no evidence that RN V completed the required annual training. Record review of personnel record for LVN W revealed hire date of 01/13/2023. Review of the training log for the previous 12 months provided by human resources revealed no evidence that LVN W completed the required annual training. Record review of personnel record for ADON X revealed hire date of 08/18/2018. Review of the training log for the previous 12 months provided by human resources revealed no evidence that ADON X completed the required annual training. Interview with HR on 10/03/2025 at 2:01 PM revealed the facility had a training packet that staff were to complete upon hire and then again annually. HR stated the training packet did not include communication training, QAPI training, or ethics training. HR stated it was the responsibility of HR and ADON to ensure staff complete the training packet upon hire and annually. HR stated by not ensuring staff completed all required training upon hire and again annually could lead to mistreatment or neglect of the residents. Interview with ADON X on 10/03/2025 at 2:10 PM revealed she and HR were responsible for ensuring staff complete their initial training upon hire and again annually. ADON X stated there was a training packet that she used to train the staff. ADON X stated she was unaware that communication training, QAPI training and ethics training were not in the packet. ADON X stated it was important to completely train staff to ensure residents received good care. Interview with DON on 10/03/2025 at 2:32 PM revealed she supervised the ADON who was responsible for ensuring staff receive training upon hire and annually. DON stated she was not aware that communication training, QAPI training and ethics training were not included in the training. DON stated by not ensuring staff completed all required training upon hire and again annually could lead to mistreatment or neglect of the residents. Interview with the Administrator on 10/03/2025 at 2:37 PM revealed he was ultimately responsible for ensuring staff received the required training upon hire and annually since he supervised HR and ADON X. The Administrator stated he was unaware that the training packet did not include communication training, QAPI training, or ethics training. The Administrator stated it was important that staff received the required training to ensure residents received good quality care. A policy identifying required training topics and frequency of training was requested on 10/03/2025 at 2:01 PM from HR and again from the Administrator on 10/03/2025 at 2:37 PM but was not provided prior to exit.		

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on interview and record review, the facility failed to ensure QAPI training was completed by new and existing staff for 19 of 24 (Administrator, DON, Dietary Manager, Activity Director, Social Worker, LVN G, LVN L, CNA M, CNA N, CNA O, Restorative Aide P, CNA Q, CNA R, CNA S, CNA T, RN U, RN V, LVN W, and ADON X) employees reviewed for training requirements. The facility failed to provide QAPI training was completed by Social Worker, Dietary Manager and Restorative Aide P upon hire. The facility failed to provide QAPI training was completed by Administrator, DON, Activity Director, LVN G, LVN L, CNA M, CNA N, CNA O, CNA Q, CNA R, CNA S, CNA T, RN U, RN V, LVN W, and ADON X annually. This failure could place residents at risk of being cared for by staff who have been insufficiently trained. The findings were: Record review of personnel record for Administrator revealed hire date of 02/08/2021. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the Administrator completed QAPI training annually. Record review of personnel record for DON revealed hire date of 11/21/2022. Review of training log for the previous 12 months provided by human resources revealed no evidence that DON completed QAPI training annually. Record review of personnel record for Dietary Manager revealed hire date of 09/02/2025. Review of the training log provided by human resources revealed the Dietary Manager did not complete QAPI training upon hire. Record review of personnel record for Activity Director revealed hire date of 01/05/2021. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the Activity Director completed QAPI training annually. Record review of personnel record for Social Worker revealed hire date of 09/02/2025. Review of training log provided by human resources revealed the Social Worker did not complete QAPI training upon hire. Record review of personnel record for LVN G revealed hire date of 02/10/2021. Review of the training log for the previous 12 months provided by human resources revealed no evidence that LVN G completed QAPI training annually. Record review of personnel record for LVN L revealed hire date of 06/24/2022. Review of the training log for the previous 12 months provided by human resources revealed no evidence that LVN L completed QAPI training annually. Record review of personnel record for CNA M revealed hire date of 08/02/2024. Review of the training log for the previous 12 months provided by human resources revealed no evidence that CNA M completed QAPI training annually. Record review of personnel record for CNA N revealed hire date of 12/20/2023. Review of training log for the previous 12 months provided by human resources revealed no evidence that CNA N completed QAPI training annually. Record review of personnel record for CNA O revealed hire date of 11/08/2023. Review of the training log for the previous 12 months provided by human resources revealed no evidence that CNA O completed QAPI training annually. Record review of personnel record for Restorative Aide P revealed hire date of 08/26/2025. Review of training log provided by human resources revealed Restorative Aide P did not complete the QAPI training upon hire. Record review of personnel record for CNA Q revealed hire date of 01/23/2023. Review of the training log for the previous 12 months provided by human resources revealed no evidence that CNA Q completed QAPI training annually. Record review of personnel record for CNA R revealed hire date of 02/10/2021. Review of the training log for the previous 12 months provided by human resources revealed no evidence that CNA R completed QAPI training annually. Record review of personnel record for CNA S revealed hire date of 01/23/2022. Review of the training log for the previous 12 months provided by human resources revealed no evidence that CNA S completed QAPI training annually. Record review of personnel record for CNA T revealed hire date of 06/06/2024. Review of the training log for the previous 12 months provided by human resources revealed no evidence that CNA T completed QAPI training annually. Record review of personnel record for RN U revealed hire date of 09/21/2022. Review of the training log for the previous 12 months provided by human resources revealed no evidence that RN U completed QAPI training annually. Record review of personnel record for RN V (continued on next page)		

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed hire date of 03/07/2024. Review of training log for the previous 12 months provided by human resources revealed no evidence that RN V completed QAPI training annually. Record review of personnel record for LVN W revealed hire date of 01/13/2023. Review of the training log for the previous 12 months provided by human resources revealed no evidence that LVN W completed QAPI training annually. Record review of personnel record for ADON X revealed hire date of 08/18/2018. Review of the training log for the previous 12 months provided by human resources revealed no evidence that RN X completed QAPI training annually. Interview with HR on 10/03/2025 at 2:01 PM revealed the facility had a training packet that staff were to complete upon hire and then again annually. HR stated the training packet does not include QAPI training. HR stated it was the responsibility of HR and ADON to ensure staff complete the training packet upon hire and annually. HR stated by not ensuring staff completed all required training upon hire and again annually could lead to mistreatment or neglect of the residents. Interview with ADON X on 10/03/2025 at 2:10 PM revealed she and HR were responsible for ensuring staff complete their initial training upon hire and again annually. ADON X stated there was a training packet that she used to train the staff. ADON X stated she was unaware that QAPI training was not in the packet. ADON X stated it was important to completely train staff to ensure residents received good care. Interview with DON on 10/03/2025 at 2:32 PM revealed she supervised the ADON who was responsible for ensuring staff receive training upon hire and annually. DON stated she was not aware that QAPI training was not included in the training. DON stated by not ensuring staff completed all required training upon hire and again annually could lead to mistreatment or neglect of the residents. Interview with the Administrator on 10/03/2025 at 2:37 PM revealed he was ultimately responsible for ensuring staff received the required training upon hire and annually since he supervised HR and ADON X. The Administrator stated he was unaware that the training packet does not include QAPI training. The Administrator stated it was important that staff received the required training to ensure residents received good quality care. A policy identifying required training topics and frequency of training was requested on 10/03/2025 at 2:01 PM from HR and again from the Administrator on 10/03/2025 at 2:37 PM but was not provided prior to exit.		

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on interview and record review, the facility failed to ensure ethics training was completed by new and existing staff for 19 of 24 (Administrator, DON, Dietary Manager, Activity Director, Social Worker, LVN G, LVN L, CNA M, CNA N, CNA O, Restorative Aide P, CNA Q, CNA R, CNA S, CNA T, RN U, RN V, LVN W, and ADON X) employees reviewed for training requirements. The facility failed to ensure ethics training was completed by Social Worker, Dietary Manager and Restorative Aide P upon hire. The facility failed to ensure ethics training was completed by Administrator, DON, Activity Director, LVN G, LVN L, CNA M, CNA N, CNA O, CNA Q, CNA R, CNA S, CNA T, RN U, RN V, LVN W, and ADON X annually. This failure could place residents at risk of being cared for by staff who have been insufficiently trained. The findings were: Record review of personnel record for Administrator revealed hire date of 02/08/2021. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the Administrator completed ethics training annually. Record review of personnel record for DON revealed hire date of 11/21/2022. Review of training log for the previous 12 months provided by human resources revealed no evidence that DON completed ethics training annually. Record review of personnel record for Dietary Manager revealed hire date of 09/02/2025. Review of the training log provided by human resources revealed the Dietary Manager did not complete ethics training upon hire. Record review of personnel record for Activity Director revealed hire date of 01/05/2021. Review of the training log for the previous 12 months provided by human resources revealed no evidence that the Activity Director completed ethics training annually. Record review of personnel record for Social Worker revealed hire date of 09/02/2025. Review of training log provided by human resources revealed the Social Worker did not complete ethics training upon hire. Record review of personnel record for LVN G revealed hire date of 02/10/2021. Review of the training log for the previous 12 months provided by human resources revealed no evidence that LVN G completed ethics training annually. Record review of personnel record for LVN L revealed hire date of 06/24/2022. Review of the training log for the previous 12 months provided by human resources revealed no evidence that LVN L completed ethics training annually. Record review of personnel record for CNA M revealed hire date of 08/02/2024. Review of the training log for the previous 12 months provided by human resources revealed no evidence that CNA M completed ethics training annually. Record review of personnel record for CNA N revealed hire date of 12/20/2023. Review of training log for the previous 12 months provided by human resources revealed no evidence that CNA N completed ethics training annually. Record review of personnel record for CNA O revealed hire date of 11/08/2023. Review of the training log for the previous 12 months provided by human resources revealed no evidence that CNA O completed ethics training annually. Record review of personnel record for Restorative Aide P revealed hire date of 08/26/2025. Review of training log provided by human resources revealed Restorative Aide P did not complete the ethics training upon hire. Record review of personnel record for CNA Q revealed hire date of 01/23/2023. Review of the training log for the previous 12 months provided by human resources revealed no evidence that CNA Q completed ethics training annually. Record review of personnel record for CNA R revealed hire date of 02/10/2021. Review of the training log for the previous 12 months provided by human resources revealed no evidence that CNA R completed ethics training annually. Record review of personnel record for CNA S revealed hire date of 01/23/2022. Review of the training log for the previous 12 months provided by human resources revealed no evidence that CNA S completed ethics training annually. Record review of personnel record for CNA T revealed hire date of 06/06/2024. Review of the training log for the previous 12 months provided by human resources revealed no evidence that CNA T completed ethics training annually. Record review of personnel record for RN U revealed hire date of 09/21/2022. Review of the training log for the previous 12 months provided by human resources revealed no evidence that RN U completed ethics training annually. Record review of (continued on next page)		

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

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	personnel record for RN V revealed hire date of 03/07/2024. Review of training log for the previous 12 months provided by human resources revealed no evidence that RN V completed ethics training annually. Record review of personnel record for LVN W revealed hire date of 01/13/2023. Review of the training log for the previous 12 months provided by human resources revealed no evidence that LVN W completed ethics training annually. Record review of personnel record for ADON X revealed hire date of 08/18/2018. Review of the training log for the previous 12 months provided by human resources revealed no evidence that ADON X completed ethics training annually. Interview with HR on 10/03/2025 at 2:01 PM revealed the facility had a training packet that staff were to complete upon hire and then again annually. HR stated the training packet does not include ethics training. HR stated it was the responsibility of HR and ADON to ensure staff complete the training packet upon hire and annually. HR stated by not ensuring staff completed all required training upon hire and again annually could lead to mistreatment or neglect of the residents. Interview with ADON X on 10/03/2025 at 2:10 PM revealed she and HR were responsible for ensuring staff complete their initial training upon hire and again annually. ADON X stated there was a training packet that she used to train the staff. ADON X stated she was unaware that ethics training was not in the packet. ADON X stated it was important to completely train staff to ensure residents received good care. Interview with DON on 10/03/2025 at 2:32 PM revealed she supervised the ADON who was responsible for ensuring staff receive training upon hire and annually. DON stated she was not aware that ethics training was not included in the training. DON stated by not ensuring staff completed all required training upon hire and again annually could lead to mistreatment or neglect of the residents. Interview with the Administrator on 10/03/2025 at 2:37 PM revealed he was ultimately responsible for ensuring staff received the required training upon hire and annually since he supervised HR and ADON X. The Administrator stated he was unaware that the training packet does not include ethics training. The Administrator stated it was important that staff received the required training to ensure residents received good quality care. A policy identifying required training topics and frequency of training was requested on 10/03/2025 at 2:01 PM from HR and again from the Administrator on 10/03/2025 at 2:37 PM but was not provided prior to exit.		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure CNAs received the required minimum 12 hours annual in-services for 7 of 7 (CNA M, CNA N, CNA O, CNA Q, CNA R, CNA S, CNA T) CNAs reviewed for trainings requirements. The facility failed to provide the required 12 hours of annual training to CNA M, CNA N, CNA O, CNA Q, CNA R, CNA S, CNA T. This failure could place residents at risk of being cared for by staff who have been insufficiently trained. The findings were: Record review of personnel record for CNA M revealed hire date of 08/02/2024. Review of training log for the previous 12 months provided by human resources revealed evidence of less than 12 hours per year of required in-service training being provided annually. Record review of personnel record for CNA N revealed hire date of 12/20/2023. Review of training log for the previous 12 months provided by human resources revealed evidence of less than 12 hours per year of required in-service training being provided annually. Record review of personnel record for CNA O revealed hire date of 11/08/2023. Review of training log for the previous 12 months provided by human resources revealed evidence of less than 12 hours per year of required in-service training being provided annually. Record review of personnel record for CNA Q revealed hire date of 01/23/2023. Review of training log for the previous 12 months provided by human resources revealed evidence of less than 12 hours per year of required in-service training being provided annually. Record review of personnel record for CNA R revealed hire date of 02/10/2021. Review of training log for the previous 12 months provided by human resources revealed evidence of less than 12 hours per year of required in-service training being provided annually. Record review of personnel record for CNA S revealed hire date of 01/23/2022. Review of training log for the previous 12 months provided by human resources revealed evidence of less than 12 hours per year of required in-service training being provided annually. Record review of personnel record for CNA T revealed hire date of 06/06/2024. Review of training log for the previous 12 months provided by human resources revealed evidence of less than 12 hours per year of required in-service training being provided annually. Interview with HR on 10/03/2025 at 2:01 PM revealed the facility had a training packet that staff were to complete upon hire and then again annually. HR stated the training packet does not include communication training, QAPI training, or ethics training. HR stated it was the responsibility of HR and ADON to ensure staff complete the training packet upon hire and annually. HR stated by not ensuring staff completed all required training upon hire and again annually could lead to mistreatment or neglect of the residents. Interview with ADON X on 10/03/2025 at 2:10 PM revealed she and HR were responsible for ensuring staff complete their initial training upon hire and again annually. ADON X stated there was a training packet that she used to train the staff. ADON X stated she was unaware that communication training, QAPI training and ethics training was not in the packet. ADON X stated it was important to completely train staff to ensure residents received good care. Interview with DON on 10/03/2025 at 2:32 PM revealed she supervised the ADON who was responsible for ensuring staff receive training upon hire and annually. DON stated she was not aware that communication training, QAPI training and ethics training were not included in the training. DON stated by not ensuring staff completed all required training upon hire and again annually could lead to mistreatment or neglect of the residents. Interview with the Administrator on 10/03/2025 at 2:37 PM revealed he was ultimately responsible for ensuring staff received the required training upon hire and annually since he supervised HR and ADON X. The Administrator stated he was unaware that the training packet does not include communication training, QAPI training, or ethics training. The Administrator stated it was important that staff received the required training to ensure residents received good quality care. A policy identifying required training topics and frequency of training was requested on 10/03/2025 at 2:01 PM from HR and again from the Administrator on 10/03/2025 at 2:37 PM but was not provided prior to exit.		

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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** Based on observations, interviews and record reviews, the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 resident (Resident #37) of 3 residents observed with indwelling urinary catheter care. The facility failed to ensure Resident #37 had an indwelling urinary catheter leg strap. This facility failure affects residents with indwelling urinary catheter's and could result in pain, inflammation, dislodgement, and urinary tract infections. The findings included:Record review of Resident #37's electronic face sheet dated 10/02/2025 reflected she was a [AGE] year-old female who was readmitted to the facility on [DATE]. Her diagnoses included fracture of unspecified part of neck of left femur (a break in the neck of the thigh bone), chronic obstructive pulmonary disease (lung disease characterized by ongoing inflammation and narrowing of the airways, leading to airflow obstruction and breathing difficulties), permanent atrial fibrillation (condition where the heart's upper chambers beat irregularly and rapidly for an extended period, and it is not possible to restore a normal heart rhythm through treatment), and retention of urine (inability to empty the bladder completely). Record review of Resident #37's annual MDS assessment with an ARD of 07/24/2025 reflected that she could understand and be understood. She scored a 10 of 15 on her BIMS which indicated her cognitive status was moderately impaired. She had an indwelling urinary catheter. She required partial assistance with her ADLs. Record review of Resident #37's comprehensive care plan dated 04/04/2025 reflected Focus, has an indwelling catheter, interventions, check tubing for kinks each shift. Resident #37's need for a urinary catheter leg strap was not reflected. Record review of Resident #37's Active Orders as of: 10/02/2025 reflected Foley leg strap/tubing: secure tubing with leg strap in place at all times to prevent pulling, start date 08/14/2024.Observation on 10/02/2025 at 08:55 am revealed CNA C performed catheter care for Resident #37, Resident #37 did not have a leg strap. Interview on 10/02/2025 at 09:09 am, CNA C stated Resident #37 usually had a leg strap for her catheter to keep the catheter tubing from pulling and causing discomfort. She stated the nurses monitored the catheter tubing and leg strap. Observation on 10/03/2025 at 07:34 am of Resident #37 revealed she was sitting on the side of her bed in her room and did not have a catheter leg strap in place. Interview on 10/03/2025 at 07:35 am, Resident #37 stated she preferred having a catheter leg strap in place because when the catheter tubing pulled, she felt discomfort. During an interview on 10/03/2025 at 08:56 am, the DON stated it was important for the care plan to be accurate because it communicated to others the residents care requirements or preferences. She stated Resident #37 wanted a urinary catheter leg strap to keep the tubing from pulling or dislodging the bulb that held it in place. She stated trauma to the neck of the bladder could occur and the potential for infections. She stated she was accountable for nursing care in the facility. She stated the leg strap may have gotten wet in the shower and was never replaced. She stated unless a resident refused a leg band it was a standard of care for indwelling urinary catheters. Record review of the facility policy and procedure titled Catheter Care, Urinary, dated September 2014 reflected secure catheter utilizing a leg band.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 store medications under appropriate conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security for 1 (200-A unit) of 4 medication carts reviewed for storage. In 200-A unit nursing cart, Resident #47's brand-new eye drop (Latanoprost) was stored at the room temperature on [DATE], but per the label of the eye drop indicated refrigerate. This failure could place residents at risk of not receiving therapeutic effects by using medications that were not refrigerated. The findings included: Record review of Resident #47's face sheet, dated [DATE], revealed the resident was 54-years-old female and admitted to the facility on [DATE] with diagnoses of diffuse traumatic brain injury (tearing of the brain's long connecting nerve fibers that happens when the brain is injured), ataxic gait (poor muscle control that causes clumsy movements), hemiplegia (paralysis of one side of the body), other seasonal allergic rhinitis (runny nose and itch eyes), and dysphagia (difficulty swallowing). Record review of Resident #47's quarterly MDS assessment, dated [DATE], revealed the resident's BIMS was 9 out of 15 indicating the resident had moderate cognitive impairment. Record review of Resident #47's physician's order, dated [DATE], revealed the resident had the order of Latanoprost Ophthalmic Solution 0.005 % (Latanoprost), Instill 1 drop in both eyes every evening shift for eyes. Observation on [DATE] at 2:11 p.m. revealed Resident #47's brand-new eye drops (Latanoprost) were stored at room temperature in the 200-A unit nursing cart. Further observation revealed the resident's brand-new eye drops were labeled Refrigerate on the box. During an interview on [DATE] at 2:17 p.m. LVN-I stated Resident #47's brand-new eye drops (Latanoprost) were stored at room temperature in the 200-A unit nursing cart, but the resident's brand-new eye drops were labeled Refrigerate on the box. Further interview with LVN-I revealed the facility nurses should have stored Resident #47's brand-new eye drops (Latanoprost) in a refrigerator because the label said, Refrigerate. LVN-I said she saw the medication was stored inside the 200-A unit nursing cart since [DATE], but he did not know how long or the reason why the eye drops were stored on the cart instead of the refrigerator. During an interview on [DATE] at 2:17 p.m. the DON stated Resident #47's brand-new eye drops (Latanoprost) would not reach therapeutic effects. Record review of the facility policy, titled Storage of Medications, undated, revealed . 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed, and for storage and expiration - diabetes injections. For Humalog vial (Insulin lispro) and Novolog vial (Insulin aspart), expired 28 days after opening.		

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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 observation, interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 32 residents (Resident #75) reviewed for accuracy of medical records. The facility failed to ensure Resident #75's oxygen therapy was documented on her MAR. This deficient practice could affect residents whose records are maintained by the facility and could place them at risk for errors in care and treatment. The findings included: Record review of Resident #75's electronic face sheet dated 09/30/2025 reflected she was an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: Alzheimer's disease (progressive brain disorder that causes memory loss, confusion, and other cognitive decline), dysphagia (difficulty swallowing foods and liquids), anxiety disorder (mental health condition characterized by excessive worry, fear, and nervousness that can interfere with daily life) , repeated falls (two or more falls occurring within a specific timeframe, most commonly defined as a 12-month period but sometimes also using a 6-month period), dementia (general term for a group of brain disorders that cause a progressive decline in cognitive abilities, such as: memory, thinking, language, judgment, problem-solving, and behavior), bipolar disorder (a chronic mental health condition characterized by extreme mood swings between periods of mania (elevated mood) and depression) and psychosis (mental health condition characterized by a loss of touch with reality). Record review of Resident #75's annual MDS assessment with an ARD of 08/21/2025 reflected she was usually understood and sometimes understands. She scored 3 of 15 on her BIMS which indicated her cognitive status was severely impaired. She was dependent on her ADLs. She did not have oxygen therapy. Record review of Resident #75's comprehensive care plan dated 09/09/2025 reflected Focus, treated for URI and had experienced SOB with exertion, interventions, administer oxygen as directed by physician. Record review of Resident #75's Active Orders as of: 09/30/2025 reflected Oxygen at 2-5 L/Min via NC as needed for SOB, maintain O2 saturations greater than 92% as needed, start date 09/22/25. Record review of Resident #75's progress notes written by LVN A for 09/22/2025, 09/23/2025 and 09/24/2025 reflected Resident #75 received oxygen at 2L/Min via NC for SOB. Record review of Resident #75's O2 Saturation Summary (undated) reflected she received oxygen via NC on 09/22/2025, 09/23/2025 and 09/24/2025. Record review of Resident #75's MAR dated September 01-September 30 reflected no initials were present for her PRN oxygen for 09/22/2025, 09/23/2025 and 09/24/2025. Observation on 09/30/2025 at 09:40 am of Resident #75's room revealed an oxygen concentrator with oxygen tubing with NC unbagged and draped over the machine. Interview on 10/01/2025 at 07:30 am, LVN A stated Resident #75's oxygen order was a new order, and she did not think it was on the MAR. She stated she did not look for it on the MAR, checked the resident's saturations and provided the oxygen as ordered. She stated care documentation is a professional standard, and she should have checked and initialed Resident #75's MAR. During an interview on 10/03/2025 at 08:56 am, the DON, stated documentation of nursing care is a professional expectation, and she did not know why it was not done. She stated if it was not documented, it was not done. She stated the MAR was an official part of the resident's clinical record and needed to be completed. She stated she was accountable for the nursing care at the facility, and nurses are trained from school on how and what to document. Record review of the facility policy and procedure titled Safety and Supervision of Residents Oxygen dated 11/28/24 reflected under documentation the date and time the procedure was performed, and the name and title of the individual who performed the procedure.		

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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 observations, interviews and record reviews, the facility failed to establish and 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 residents (Resident #57 and #88) of 32 residents observed for infection control. 1. CNA D failed to change her gloves and sanitize her hands between soiled and clean items when she performed incontinent care for Resident #57. 2. CNA C failed to change her gloves and sanitize her hands between soiled and clean items when she and CNA B performed incontinent care for Resident #88. These failures could affect residents and place them at risk for infection. The findings included: 1. Record review of Resident #57's electronic face sheet dated 10/02/2025 reflected she was a [AGE] year-old female who was readmitted to the facility on [DATE]. Her diagnoses included: senile degeneration of brain (progressive deterioration of brain tissue and function), anxiety disorder (a feeling of worry, nervousness, or unease), dysphagia (difficulty swallowing) and schizophrenia (a serious mental health condition that affects how people think, feel, and behave). Record review of Resident #57's quarterly MDS assessment with an ARD of 08/15/2025 reflected that she could usually understand and be understood. She scored an 8 of 15 on her BIMS which indicated her cognitive status was moderately impaired. She required moderate to extensive assistance with her ADLs. She was frequently incontinent with bowel and bladder. Record review of Resident #57's comprehensive care plan dated 04/15/2025 reflected Focus, resident is at risk for bowel and bladder incontinence, intervention and goal, keep resident clean, dry and odor free. Observation on 10/01/2025 at 4:09 pm of CNA D performing incontinent care for Resident #57 revealed she cleaned the labia and perineal area (thin layer of skin between the anus and the genitals), took her soiled gloves off, sanitized her hands, put on clean gloves, then cleaned the backside of the resident. CNA D went to clean her hands and put on clean gloves, returned to the bed, and took the clean brief and placed it under Resident #57. She then pulled up the soiled brief from beneath the resident and discarded it. CNA D did not clean hands or change her gloves and continued to complete care after working with the soiled brief. CNA D finished closing the clean brief and straightening out the resident's bedding. During an interview on 10/01/2025 with CNA D, she stated that she forgot to clean her hands again and to put clean gloves on after she took off the residents soiled brief. She stated that cross contamination could occur and cause an infection. She stated she was trained to keep clean and soiled apart from each other. 2. Record review of Resident #88's electronic face sheet reflected he was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included: atherosclerotic heart disease (hardening of the arteries from plaque buildup inside them which limits the flow of blood to the brain and heart), type II diabetes mellitus (a condition that affects how the body uses insulin and sugar), dementia (group of symptoms affecting memory, thinking and social abilities), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest) and peripheral vascular disease (disorder of the blood vessels outside the heart, and can affect the legs, feet, brain and other organs). Record review of Resident #88's quarterly MDS assessment with an ARD of 07/04/2025 reflected he could understand and be understood. He scored 12 of 15 on his BIMS which indicated his cognitive status was moderately impaired. He was dependent on most of his ADLs. He was always incontinent of bowel and bladder. Record review of Resident #88's comprehensive care plan dated 04/07/2025 reflected Focus, incontinent of bowel and bladder, interventions/goals, keep clean and dry. Observation on 10/02/2025 at 3:30 pm of CNA C and CNA B performing incontinent care for Resident #88 revealed CNA C sanitized her hands and put on clean gloves. She cleaned Resident #88's penis, scrotal area and backside. She then was reminded by CNA B to change the draw sheet which was underneath the resident. CNA C grabbed the clean brief and placed it under the resident with her soiled gloves. She (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then proceeded to finish pulling through the soiled drawsheets and then picked up the clean brief with her soiled gloves and put it back on her clean area. She then took off her soiled gloves and sanitized her hands and put on clean gloves and grabbed the same brief off the bedside table and reapplied the brief to the resident. During an interview on 10/02/2025 at 3:55 pm with CNA C, she stated she should have gotten a clean brief instead of using the one she had touched with the soiled gloves. She stated cross contamination could occur and cause infections for the residents. She stated she was trained not to mix clean linens with soiled items. During an interview on 10/03/2025 at 08:56 am, the DON stated that she was accountable for the nursing care in the facility. She stated that not sanitizing hands and changing gloves when performing peri care could result in cross contamination, spread of bacteria and lead to urinary tract infections. She stated oxygen tubing when not in use needed to be bagged to prevent particles in the air to get into the equipment. Record review of Clinical Competency Validation, Perineal Care for CNA C and CNA D dated 07/22/25 reflected Cleans hands, puts on gloves, after cleaning soiled areas, wash hands and applies clean gloves. Record review of the facility policy and procedure titled Perineal Care dated February 2018 reflected discard disposable items into designated containers, remove gloves and discard into designated container, wash and dry hands thoroughly, reposition the resident's bed covers.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, and sanitary environment for 2 (Resident #37's room and Resident #8's room) out of 8 Residents' rooms reviewed, in that: 1. In Resident #37's restroom, the floor of the shower area was wet because the shower head was leaking water. 2. In Resident #8's restroom, there were human feces on the floor of the restroom. This deficient practice could result in residents living, staff working, and families visiting in an unsafe, unclean, and unpleasant environment. The findings were: 1. Record review of Resident #37's face sheet, dated 10/03/2025, revealed the resident was a [AGE] year-old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnoses of fracture of unspecified part of neck of left femur Chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems), muscle weakness, and obstructive and reflux uropathy (condition in which the flow of urine is blocked). Record review of Resident #37's annual MDS assessment, dated 07/24/2025, revealed the resident's BIMS score was 10 out of 15 indicating the resident had moderate cognitive impairment and was Independent (Resident completes the activity by himself with no assistance from a helper) to sit to stand, chair to bed, toilet transfer, and walk with a walker. Record review of Resident #37's comprehensive care plan, dated 08/05/2025, revealed Risk for falls characterized by history of falls/ injury, multiple risk factors related to: impaired balance. For intervention - Ensure environment is free of clutter. Observation on 09/30/2025 at 9:50 a.m. revealed there was a restroom in Resident #37's room, and the restroom had toilet area and shower area without divider. The floor of the shower area was wet with water because the shower head was leaking water. During an interview on 09/30/2025 at 2:28 p.m. with Resident #37 she stated she could use her restroom by herself for showers and toileting, and she did not know the floor of the resident's shower area was wet because the shower head was leaking water. Further interview with Resident #37 revealed she did not have any problem when using her restroom regarding falls, and the facility cleaned her restroom every day. During an interview on 09/30/2025 at 10:54 a.m. RN-K stated in Resident #37's restroom, the floor of the shower area was wet because the shower head was leaking water. RN-K said he worked on 09/29/2025 and did not see any leaking water, so leaking water from the shower head in Resident #37's restroom started on 09/30/2025, and it should have been fixed immediately to prevent possible falls. During an interview on 10/03/2025 at 9:13 a.m. Maintenance stated RN-K reported that the floor of the shower area in Resident #37's restroom was wet because the shower head was leaking water, so the Maintenance fixed it immediately to prevent possible falls, and there was not any other leaking water in the facility. 2. Record review of Resident #8's face sheet, dated 10/03/2025, revealed the resident was 83-years-old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnoses of senile degeneration of brain (a decline in an individual's memory, behavior, and cognitive abilities), Alzheimer's disease (progressive disease that destroy memories and other important mental functions), muscle wasting and atrophy (loss of skeletal muscle mass), and chronic kidney disease stage 1 (mild damage to the kidneys). Record review of Resident #8's quarterly MDS assessment, dated 08/24/2025, revealed the resident's BIMS score was 0 out of 15 indicating the resident had severe cognitive impairment, required Partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) to chair to bed, toilet transfer, and walk, and had frequent urinary incontinence and occasional bowel incontinence. Record review of Resident #8's comprehensive care plan, dated 07/15/2025, revealed The resident is high risk for falls related to resident has no safety awareness confusion, Gait/balance problems, unaware of safety needs, and wandering. For intervention - Ensure environment is free of clutter-humidifier removed. Observation on 09/30/2025 at 10:19 a.m. revealed there was a small lump with brown color on the (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	floor at the left side of toilet inside Resident #8's restroom, and the small lump was old and looked like human feces. An interview was attempted on 09/30/2025 at 10:20 a.m. with Resident #8, but the resident was not able to interview due to impaired cognitive functions. During an interview on 09/30/2025 at 10:35 a.m. LVN-L stated she saw a small lump with brown color on the floor at the left side of toilet inside Resident #8's restroom at the same time as this surveyor and said it was human feces. LVN-L said she did not know what reason the feces were on the floor in Resident #8's restroom because housekeepers cleaned the room every day, and it was not fresh but old. LVN-L said Resident #8's restroom should have been clean always to prevent possible fall and for the resident's quality of life. During an interview on 10/03/2025 at 9:30 a.m. Housekeeping Director stated housekeepers cleaned each resident's room and restroom every day for safety and quality of life, and the Housekeeping Director thought that CNAs working overnight might not clean because the feces found in Resident #8's restroom was old. During an interview on 10/03/2025 at 9:36 a.m. DON said Resident #37 and #8's restrooms should have been clean to prevent possible falls. Record review of the facility policy, titled Quality of Life - Homelike Environment, undated revealed . 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Clean, sanitary and orderly environment.		