

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

Printed: 12/04/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676402	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER Windemere at Westover Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 11106 Christus Hills 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 41651 Based on interview and record review, the facility failed to promote the residents' right to receive mail, for all facility residents, in that: Facility staff did not distribute mail received on Saturdays to the residents. This deficient practice could result in residents not receiving mail in a timely manner and a diminished quality of life. The findings were: During a confidential group meeting on 09/12/2024 at 11:00 a.m., members of the resident group stated that they do not receive mail on Saturdays and stated they feel this practice is disrespectful. During an interview with Receptionist G on 09/12/2024 at 4:24 p.m., Receptionist G stated she had been directed by person who hired her (no longer with facility) to place all mail received on Saturdays, including resident mail, in the Business Office Manager's (BOM) mailbox, and confirmed the BOM does not work on weekends. During an interview with the BOM on 09/12/2024 at 4:32 p.m., the BOM confirmed she does not work on weekends, stated all mail received on Saturday is left in her box by receptionist, she distributes to intended recipients, and gives resident mail to the Activity Director (AD) to distribute to residents on Mondays. During an interview with the AD on 09/13/2024 at 11:02 a.m., the AD confirmed that resident mail received on Saturdays is not given to residents until Monday because mail is received in the late afternoon after the weekend Manager on Duty has left for the day, and confirmed resident mail is left for her to distribute to residents on Mondays. During an interview with the Administrator on 09/13/2024 at 1:12 p.m., the Administrator confirmed that residents should receive their mail on Saturdays and stated that the facility practice would change to ensure resident mail is disbursed on the day it is received. Record review of the facility policy, Resident Rights, revised February 2021, revealed, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . cc. access to a telephone, mail, and email .		

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on interview and record review the facility failed to assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months for 1 of 5 Residents (Resident #45) whose records were reviewed. MDS Staff failed to ensure Resident #45's quarterly MDS assessment, dated 9/13/24m was completed within 120 days of the annual MDS assessment, dated 5/6/24 This deficient practice could affect any resident and result in resident's not receiving the needed services. The findings were: Review of Resident #45's face sheet, undated, revealed she was admitted to the facility on [DATE] with diagnosis of vascular Dementia unspecified. Review of Resident #45's MDS history revealed she had an annual MDS assessment completed on 5/6/24 and then the following quarterly MDS assessment was not completed until 9/13/24; 130 days later. Interview on 09/13/24 at 03:53 PM with LVN A revealed the most recent quarterly MDS assessment was completed on 9/13/24. She stated the previous annual MDS assessment was completed on 5/19/24. LVN A stated they had 3 months to complete an assessment according to the MDS RAI. She further stated it was important to complete the assessments timely because they drove the resident Care Plan which identified the care and services each resident would receive based on their needs. Interview on 9/13/24 at 4 PM with the ADON revealed she stated each resident's assessment was due every 3 months; 120 days. The ADON also stated it was important for staff to assess the resident's functional capabilities timely because it drove the Care Plan and it identified the care and services the resident would receive. Review of a facility policy, Comprehensive Assessments revised March 2020 read, Comprehensive assessments are conducted to assist in developing person-centered care plans. 1. Comprehensive assessments are conducted in accordance with criteria and timeframe's established in the Resident Assessment Instrument (RAI) User Manual.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on interview and record review the facility failed to ensure each assessment must accurately reflect the resident's status for 2 of 13 Residents (Resident #27 and Resident #45) reviewed for accuracy of assessments. 1. MDS staff failed to ensure Resident #27's quarterly MDS, 6/10/24, reflected she had a range of motion impairment on her upper extremity. 2. MDS staff coded Resident #45's quarterly MDS assessment, dated 9/13/24, having a significant weight loss. Resident #45 did not experience a significant weight loss during the look back period. These deficient practitioners could affect residents by inaccurately reflecting their status which could contribute to residents not receiving necessary care and services. The findings were: 1. Review of MDS history dating back to 2021 revealed Resident #27 had a history of ROM impairment on upper and lower extremity. Review of Resident #27's quarterly MDS, dated [DATE], revealed Resident #27 had ROM impairment to lower extremity and she received Occupational services. Review of Occupational Therapy note, dated 6/10/24, revealed Resident #27 had left-sided hemiplegia. Review of Resident #27's Care Plan, dated 2/26/23, revealed Resident #27 had left-sided hemiparesis related to CVA (Stroke). 2. Review of Resident #45's face sheet, undated, revealed she was admitted to the facility on [DATE] with diagnosis of vascular Dementia unspecified. Review of Resident #45's quarterly MDS assessment, dated 9/13/24, revealed Resident #45 experienced a significant weight loss. Review of Resident #45's weights revealed on 6/14/24 she weighed 150 pounds and on 9/10/24 she weighed 157.80. Review of Resident #45's Care Plan, dated, 5/31/23, revealed K/0300.1 Weight loss; 5% or more in last 30 days (7/6/2023 -18.40 LBS); 9/12/23 Wt loss: Triggered for -28.5lbs/-14.59lbs x 90 days; 1/5/24- 153.20 continues with weight loss - 7.93 in 90 days; 3/8/24: (Resident #45) triggered for unintended weight loss of 7.60lbs/10.58% in 180 days. STATUS: Active (Current). (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/13/24 at 3:53 PM with LVN A revealed Resident #45's quarterly MDS assessment, dated 9/13/24, was coded for weight loss. LVN A stated in reviewing Resident #45's weights she gained weight from June 2024 to September 2024. She stated Resident 45's MDS assessment was inaccurate. She stated it was important to ensure it was accurate because it drove the Care Plan. The Care Plan was a tool nursing staff used to review the Resident's status. It guided them to provide the care and services Resident #45 needed. Interview on 09/13/24 at 4:00 PM with the ADON revealed Resident #45's MDS assessment was inaccurate. She stated assessments should be accurate as well as Care Plans because they provided nursing staff with a picture of Resident #45's status; needs. Inteview on 9/13/24 at 6:00 PM with the ADM revealed the facility did not have a policy which defined an inaccurate MDS. She stated MDS staff used the RAI as a guide for completing MDS assessments. 41651		

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a qualified health professional conducts resident assessments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on interview and record review the facility failed to ensure a registered nurse signed and certified the assessment was completed for 1 of 5 Residents (Resident #45) reviewed for assessment certification. An RN did not sign Resident #45's quarterly assessment when it was completed on 9/13/24. This deficient practice could affect any resident and result in the residents' assessment not being valid. The findings were: Review of Resident #45's face sheet, undated, revealed she was admitted to the facility on [DATE] with diagnosis of vascular Dementia unspecified. Review of Resident #45's quarterly MDS assessment completed on 9/13/24 revealed the only staff who signed it was an LVN. An RN did not sign. Interview on 09/13/24 at 3:53 PM with LVN A revealed the most recent quarterly MDS assessment, dated 9/13/24, revealed an LVN signed it but according to RAI criteria an RN had to sign off on it because an LVN could not technically conduct a resident assessment. Interview on 9/13/24 at 4:00 PM with the ADON revealed she stated an RN had to sign off because an LVN could not technically conduct a resident assessment. Review of a facility policy, Comprehensive Assessments revised March 2020 read, Comprehensive assessments are conducted and coordinated by a registered nurse with appropriate participation of other health professionals.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 3 of 3 residents (#9, #27 and #38) reviewed for PASARR services. 1. The facility failed to identify Resident #9 as having several diagnoses related to Mental Illness including paranoid schizophrenia, manor depressive disorder, panic disorder, unspecified mood [affective] disorder and anxiety disorder, on the PASARR screening which would require a PASARR Level II assessment. 2. The facility failed to identify Resident #27 as having a diagnosis of unspecified Psychosis, a mental illness, which would require a PASARR Level II assessment. 3. The facility failed to identify Resident #38 as having a diagnosis of Bipolar Disorder, a mental illness which would require a PASARR Level II assessment. These deficient practices could place residents at risk to a diminished quality of life by not receiving or benefiting from specialized services. 1. Record review of Resident #9's Face Sheet reflected an [AGE] year-old male last admitted to facility 06/12/23. The Face Sheet indicated Resident #9 had a Prior Community Stay from 03/31/23 - 05/17/23. His diagnoses included the following: * paranoid schizophrenia (a chronic condition that can cause paranoia making it hard to tell what is real and what is not), *major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest), *panic disorder (mental and behavioral disorder characterized by reoccurring unexpected panic attacks), *unspecified mood [affective] disorder (a disturbance in mood which is abnormally depressed or elated) and *anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Record review of Resident #9's PASARR Level 1 Screening dated 08/16/23 indicated No for C0090 Primary Diagnosis of Dementia and No for C0100 Is there evidence or an indicator this is an individual that has a Mental Illness. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of psychiatric assessment by contracted psychological services indicated a service date on 04/10/23. The assessment noted an admitted [DATE]. That assessment indicated a Primary Treatment Diagnosis of Paranoid Schizophrenia with a Secondary Treating Diagnoses of Panic disorder (episodic paroxysmal anxiety) without agoraphobia. The mental health assessor documented that Resident #9 told the assessor that he had dealt with mental illness issues since he was in his 20's. Resident #9 was unavailable for interviews throughout this survey since he was found asleep in his room with the door closed and lights off. During an interview, an unidentified C.N.A. indicated that Resident #9 slept all day and was awake at night. He did usually wake up for meals and then would go back to sleep. Record review of the most recent MDS dated [DATE] revealed a BIMS score of 11, indicating resident had moderate cognitive impairment. The MDS did not indicate whether or not a PASARR II assessment had been completed. During an interview on 09/13/24 at 08:30 AM, the Senior DON revealed she stated the schizophrenia diagnosis was made by [mental health assessor] after admission. The Senior DON said a Form 1012 [Mental Illness/Dementia Resident Review] should have been done to [determine whether a resident with a Negative PASARR Level needs further evaluation] and was not completed. The Senior DON stated the MDS Nurse who normally reviewed PASARR's was out on medical leave. 2. Review of Resident #27's face sheet, undated, revealed she was admitted to the facility on [DATE] with diagnosis of unspecified Psychosis. Review of Resident #27's quarterly MDS assessment, dated 6/10/24, revealed her BIMS was 0 meaning she was not able to complete the Brief Interview for Mental Status. Further review revealed she had a diagnosis of Depression. Review of Resident #27's Care Plan, effective 2/26/23, revealed she had a diagnosis of Depression w/psychotic symptoms. Review of Resident #27's PASARR Level 1 Screening, dated 8/14/23, revealed she did not have a mental illness. 3. Review of Resident #38's face sheet, undated, revealed she was admitted to the facility on [DATE] with a diagnosis of Bipolar Disorder. Review of Resident #38's quarterly MDS, dated [DATE], revealed a diagnosis of Bipolar Disorder. Review of Resident #38's Care Plan, effective 2/26/23, revealed has diagnosis of Manic Depression (Bi Polar) and can have mood swings from euphoria to depression. Review of Resident #38's PASARR Level 1 Screening, dated 8/16/23, revealed she did not have a mental illness. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/13/24 at 4:11 PM with LVN A revealed the Senior DON explained a resident with a diagnosis of mental illness would require them to complete another PASARR and submit it to the local authorities. They would decide if the resident met the criteria for specialized services. LVN A stated upon reviewing Resident #38's face sheet, it reflected a diagnosis of Bipolar Disorder and Resident #27's face sheet reflected a diagnosis of unspecified Psychosis. Record review of the facility's Assessments policy dated November 2017 addressed PASARR as follows: 8. Any specialized services or specialized rehabilitation services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the Patient's/Resident's medical record. In addition, the facility must provide or obtain the required services from an outside resource from a Medicare and/or Medicaid provider to provide any rehabilitative services such as physical therapy, speech-language pathology, occupational therapy, and rehabilitative services for mental disorders and intellectual disability, required in the Patient's comprehensive plan of care. 41095		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to ensure the interdisciplinary team reviewed and revised each resident's Care Plan after each assessment, including both the comprehensive and quarterly review assessments for 2 of 5 Residents (Resident #45 and Resident #70) whose records were reviewed. 1. MDS staff failed to revise Resident #45's Care Plan to reflect she did not experience significant weight loss. 2. MDS staff failed to revise Resident #70's Care Plan to reflect she used side rails for bed mobility. These deficient practices could contribute to residents not receiving the care and services as needed. The findings were: 1. Review of Resident #45's face sheet, undated, revealed she was admitted to the facility on [DATE] with diagnosis of vascular Dementia unspecified. Review of Resident #45's quarterly MDS assessment, dated 9/13/24, revealed Resident #45 experienced a significant weight loss. Review of Resident #45's weights revealed on 6/14/24 she weighed 150 pounds and on 9/10/24 she weighed 157.80 pounds. Review of Resident #45's CP revealed K/0300.1 Weight loss; 5% or more in last 30 days (7/6/2023 -18.40 LBS); 9/12/23 Wt loss: Triggered for -28.5 lbs/-14.59 lbs x 90 days; 1/5/24- 153.20 continues with weight loss - 7.93 in 90 days; 3/8/24: (Resident #45) triggered for unintended weight loss of 7.60 lbs/10.58% in 180 days. STATUS: Active (Current). Interview on 09/13/24 at 3:53 PM with LVN A revealed Resident #45's revealed the Care Plan, effective 5/31/24, was inaccurate and was not revised to reflect Resident #45 had not experienced significant weight loss. LVN A stated the Care Plan was a tool nursing staff used to review the Resident's status. It guided them when providing the care and services Resident #45 needed. Interview on 09/13/24 at 4:00 PM with the ADON revealed Resident #45's Care Plan, effective 5/31/24) was inaccurate. She stated Care Plans should be accurate because they provided nursing staff with a picture of Resident #45's status; care needs. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #70's face sheet, undated, revealed she was admitted to the facility on [DATE] with a diagnoses of Depression. Review of Resident #70's quarterly MDS, dated [DATE], revealed her BIMS was 15 reflecting she was alert and oriented. Review of Resident #70's physician's orders for September 2024 revealed an order for SR's for mobility and repositioning. Review of Resident #70's, effective 4/3/23, revealed did not include the use of side rails Observation and interview on 09/13/24 at 12:57 PM revealed Resident #70 sitting in bed eating lunch. The bed had two side rails up. Interview on 09/13/24 at 3:48 PM with LVN A revealed a Resident #70's Care Plan was not accurate because it did not reflect Resident #70's overall condition. Interview on 09/13/24 at 5:45 PM with the Corporate RN revealed Resident #70 used side rails while in bed. Review of a facility policy, Patient Care Management System 12, Assessments, read 6. Each Care Plan must be reviewed and updated by the interdisciplinary Care Plan team quarterly, upon each change in condition and upon re-admission.		

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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** 39075 Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 1 of 11 resident rooms (Resident #206) reviewed for storage of drugs. The facility failed to ensure medications were not left at the bedside for Resident #206. This deficient practice could place residents at risk of medication misuse or drug diversion. The findings included: Record review of Resident #206's face sheet, dated 9/11/24 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included congestive heart failure (chronic condition in which the heart doesn't pump blood as well as it should), acquired absence of lung, myasthenia gravis (a chronic autoimmune disorder that causes muscle weakness), hypotension (low blood pressure), fluid overload, gout (a type of arthritis characterized by sudden severe attacks of pain, redness, and swelling in the joints), hypokalemia (abnormally low levels of potassium in the blood), anorexia (an eating disorder characterized by an intense fear of gaining weight), and pain. Record review of Resident #206's baseline care plan, dated 9/5/24 revealed the resident was alert and cognitively intact, had disorders of the cardiac/circulatory system, and diseases and disorders of the nervous system. Record review of Resident #206's Physician Order Sheet for September 2024 revealed the following: - acetazolamide 250 mg tablet one time daily for fluid overload with order date 9/5/24 and no stop date - bumetanide 1 mg tablet two times daily for fluid overload with order date 9/5/24 and no stop date - colchicine 0.6 mg tablet one time daily for gout with order date 9/5/24 and no stop date - omeprazole 40 mg capsule, two tablets daily for gastro-esophageal reflux with order date 9/5/24 and no stop date - prednisone 20 mg tablet, (2 tablets to equal 40 mg) one time daily for myasthenia gravis with order date 9/5/24 and no stop date - spironolactone 25 mg tablet one time daily for fluid overload with order date 9/5/24 and no stop date - nystatin 100,000 unit/ml oral suspension four times daily for candida stomatitis with order date 9/6/24 and no stop date (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- midodrine 10 mg tablet three times daily for hypotension with order date 9/6/24 and no stop date - Effer-K 20 mEq effervescent tablet one time daily for hypokalemia with order date 9/7/24 and no stop date -review of the Physician Order Sheet did not have an order for the resident to self-administer medications Record review of Resident #206's MAR for September 10, 2024, revealed the following medications scheduled at 7:00 a.m., were signed out by LVN B: - acetazolamide 250 mg tablet one time daily for fluid overload - bumetanide 1 mg tablet two times daily for fluid overload - colchicine 0.6 mg tablet one time daily for gout - omeprazole 40 mg capsule, two tablets daily for gastro-esophageal reflux - prednisone 20 mg tablet, (2 tablets to equal 40 mg) one time daily for myasthenia gravis - spironolactone 25 mg tablet one time daily for fluid overload - nystatin 100,000 unit/ml oral suspension four times daily for candida stomatitis - midodrine 10 mg tablet three times daily for hypotension - Effer-K 20 mEq effervescent tablet one time daily for hypokalemia Observation on 9/10/24 at 9:45 a.m. revealed Resident #206 walking out of her room holding a medication cup with several pills in the cup. Resident #206 was intercepted by the ADON who then re-directed Resident #206, still holding the medication cup with the pills back into the resident's room. Observation on 9/10/24 at 9:47 a.m. revealed the ADON walked out of Resident #206's room. During an observation and interview on 9/10/24 at 9:47 a.m., Resident #206 was sitting up in a chair with the bedside table in front of her, and the medication cup with the pills were not seen. Resident #206 was observed with a medication cup half filled with a milky solution. Resident #206 stated she was in her room participating in a televisit appointment (a remote appointment with a doctor or other medical professional over the internet) at 8:00 a.m. with her doctor when the female CNA came into the room with the cup of pills. Resident #206 stated the doctor told her to wait and not take the pills because the doctor was going to go over the medications with her. Resident #206 stated she told the female CNA she was discussing medications with the doctor and the female CNA gave them (the cup of pills) to me and left. Resident #206 stated, the RN (ADON who was observed re-directing the resident back into her room) who came in the room took my pills and told me I was not supposed to have the pills with me. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Windemere at Westover Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 11106 Christus Hills 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 9/10/24 at 9:52 a.m. revealed the ADON returned to Resident #206's bedside with a medication cup of pills. The ADON asked Resident #206 to provide her with the name of the doctor the resident had the televisit with, wrote down the information and then placed the medication cup with the pills in front of the resident and told her to take them. Resident #206 asked the ADON to identify one of the pills she was given and the ADON stated she did not know and would have to go check, maybe vitamin C? Resident #206 retrieved the medication cup with the milky solution in it and stated she was supposed to swish and spit it out into the sink. During an interview on 9/10/24 at 9:56 a.m., the ADON stated medications were not supposed to be left at the bedside and the nursing staff were supposed to observe the resident taking the medication because if not observed the resident could throw the medications away, hoard the medications or save them for the next medication pass. The ADON stated the resident could have a negative side effect if the medications were not taken correctly. The ADON revealed she did not pull the medications she gave to Resident #206. The ADON stated, I should not be giving Resident #206 pills that I did not pull myself because I don't know what they are, but I did go verify with the nurse, LVN B. During an interview on 9/10/24 at 10:01 a.m., LVN B revealed Resident #206 was on the phone and asked the resident if she wanted to take her medications or hold the medications. LVN B stated, Resident #206 said she would take the medications. LVN B stated, I don't leave them (medications) at the bedside, but I made that exception because she (Resident #206) is alert and oriented. LVN B stated she left the medications because I just wanted to finish the med pass and help on the floor. LVN B revealed she should not have left the medications at the bedside because the resident may not take them, pocket them, or could hurt herself or have side effects from not taking her medications. During an interview on 9/12/24 at 6:46 p.m., the Senior DON stated, the nurse should not leave medications with the resident. The Senior DON stated, the nurse should not give a medication if the nurse did not pull it, draw it, or pop it because it is not best practice. The Senior DON stated the resident could have a potential negative outcome. Record review of the facility policy and procedure titled, Administering Medications, Version 2.1 revealed in part, .Medications are administered in a safe and timely manner, and as prescribed .1. Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so .		

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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. 41651 Based on observation, interview, and record review, the facility failed to store and prepare food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed, in that: Clean utensils and dishware had food particles from previous meals. This deficient practice could place residents who consumed meals and/or snacks from the kitchen at risk for food borne illness. The findings were: During a confidential group meeting on 09/12/2024 at 11:00 a.m., members of the resident group stated utensils and dishware regularly have food particles from previous meals on them. Observation of clean utensils in the kitchen on 09/13/2024 at 11:42 a.m. revealed food particles on the utensils. During an interview with Dietary Aide H, at the same time as the observation, Dietary Aide H confirmed the utensils had been cleaned and food particles remained on them. Observation of clean dishware in the kitchen on 09/13/2024 at 11:46 a.m. revealed food particles on the dishware. During an interview with Dietary Aide H, at the same time as the observation, Dietary Aide H confirmed the dishware had been cleaned and food particles remained on them. During an interview with the Dietary Manager on 09/13/2024 at 1:05 p.m., the Dietary Manager stated utensils and dishware should not have food particles remaining from previous meals and stated he would ensure that utensils and dishware were washed more thoroughly. During an interview with the Administrator on 09/13/2024 at 1:12 p.m., the Administrator stated that her expectation was that utensils and dishware should be cleaned thoroughly and not have food particles from previous meals remaining. Record review of the facility policy, Sanitization, revised November 2022, revealed, The food service area is maintained in a clean and sanitary manner.		

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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** 27520 39075 Based on observation, interview and record review the facility failed to maintain medical records on each resident that were accurately documented in accordance with accepted professional standards and practices for 3 of 10 Residents (Resident #41, Resident #32 and Resident #45) whose records were reviewed. 1. LVN C failed to document an assessment after Resident #41 had a fall. 2. Nursing staff failed to sign and date the assist rail/enabler evaluation for Resident #32 which made the evaluation invalid. 3. Nursing staff failed to obtain a consent from Resident 45's family representative for the use of an assist rail/enabler. These deficient practices could affect any residents who have medical records and could result in misinformation about professional care provided. The findings were: 1. Record review of Resident #41's face sheet, dated 9/12/24, revealed an [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), abnormalities of gait and mobility, muscle weakness, lack of coordination and history of falling. Record review of Resident #41's most recent quarterly MDS assessment, dated 8/25/24 revealed the resident was cognitively intact for daily decision-making skills, was always incontinent of bowel and bladder, and required partial/moderate assistance with chair/bed-to-chair transfer. Record review of Resident #41's comprehensive care plan, with effective date 5/29/24, revealed the resident had a potential for falls related to unsteady gait and generalized weakness and had a fall on 8/22/24 and 9/5/24. Interventions for falls included keeping areas free of obstructions, reminding the resident to request assistance with transfers and remind the resident not to take a shower without assistance. Record review of the comprehensive care plan further revealed the resident had a fall from the bed on 8/22/24 and had a rug burn to the forehead with no other injuries noted. Record review of Resident #41's Clinical Note Entry dated 8/20/24 and time stamped 10:32 p.m. by LVN C revealed the resident was moved from the 300 hall to the 700 hall due to air conditioning issues in the resident's room. Record review of Resident #41's Clinical Note Entry dated 8/28/24 and time stamped 10:30 a.m., by LVN D revealed the resident's family member voiced concerns about the resident's mental status after a recent fall and requested a CT scan of the head. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #41's Patient Visit Information from the hospital, dated 8/28/24 revealed a head CT was performed with negative results for acute intracranial abnormality and an ultrasound of the left lower extremity was negative for acute DVT. During an interview on 9/12/24 at 11:36 a.m., LVN E revealed Resident #41 was transferred from the 300 hall to the 700 hall, where the LVN was the charge nurse, on 8/21/24 because of air conditioning issues. LVN E revealed he was given report and told by the overnight charge nurse that although the resident was now on his hall, the 300 hall charge nurse who was LVN D would continue to work with the resident. LVN E stated he was notified by CNA F on 8/22/24 that Resident #41 had an unwitnessed fall and needed to be checked. LVN E stated he went to Resident #41's room and observed her already on the bed with what appeared to be a rug burn on the forehead, and since I didn't know this patient for anything, or had seen her from the day before, I didn't know if it was something new or existing. LVN E stated the resident was alert and oriented and told him she had fallen and hit her head. LVN E stated he then went to LVN D to report about the fall and stated LVN D told him the resident was not his patient. LVN E stated he then made contact with the ADON who informed him that Resident #41 was now his patient because she was moved to his hall. LVN E stated he then called the doctor and the resident's RP to report the fall. LVN E stated the NP was in the building at the time, the NP assessed the resident and did not give any new orders. LVN E stated he continued with neurological checks and assumed responsibility for the resident. During an interview on 9/12/24 at 12:58 p.m., LVN D revealed Resident #41 had been moved from the 300 hall to the 700 hall due to air conditioning issues on 8/20/24 during the overnight shift. LVN D stated he received report from the overnight nurse about the move and the resident's medications were moved to the 700 hall medication cart. LVN D stated, since the resident was moved from the 300 hall to the 700 hall, LVN E should have assumed responsibility for Resident #41. LVN D stated, LVN E brought back Resident #41's medications to him and LVN D stated, no, the patient is over there. LVN D stated he did not want to confront LVN E and informed the ADON about the matter. LVN D stated, when Resident #41 fell, it was LVN E's patient. LVN D stated, CNA F came and told me Resident #41 fell (8/22/24). Me and CNA F helped her up, I did an assessment, checked for injuries and I saw the injury to the forehead and then told CNA F to go tell LVN E that the resident had fallen. I never talked to LVN E. LVN D further stated he felt he had done his part by checking the resident and getting her up off the floor. LVN D revealed, I did not document any of that. Now I feel like I should have documented that, because after talking with you (the State Surveyor) I should have documented what I did and what I saw. During an interview on 9/12/24 at 1:15 p.m., CNA F stated he was told by LVN E that Resident #41 was moved to their hall but was not their patient. CNA F stated he continued to make his usual rounds and included Resident #41. CNA F revealed he discovered Resident #41 on the floor and reported it to LVN D but was told by LVN D that the resident belonged to LVN E. CNA F stated, my thought was, we just need to get her up. CNA F stated LVN D went to the resident's room to investigate and LVN D helped him get the resident off the floor. CNA F stated LVN D asked Resident #41 what had happened, took her vital signs, and left. During an interview on 9/12/24 at 1:46 p.m., the ADON stated, Resident #41 had an unwitnessed fall on 8/22/24, LVN D made an initial assessment but did not document it. The ADON stated, everything is wrong with that. If LVN D was saying Resident #41 was not his patient, LVN D should have notified LVN E, and they should have assessed the resident together. Here nor there, if it's not documented, it didn't happen. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #32's quarterly MDS, dated [DATE] revealed she was admitted to the facility on [DATE] with diagnosis of Heart Failure. Review of Resident #32's assist rail/enabler evaluation, dated with admitted [DATE] was not signed or dated by the nurse who conducted the evaluation. Observation on 09/10/24 at 10:24 AM revealed Resident #32 was lying in bed with two side rails up. Interview on 9/13/24 at 4:11 PM with LVN A revealed the admitting nurse typically assessed residents for the use of side rails. Interview on 9/13/24 at 5:30 PM with the RN Consultant revealed the admitting nurse did not sign or date the side rail evaluation for Resident #32 making the evaluation invalid. She stated staff was to make sure all resident documents were completely filled out. 3. Review of Resident #45's face sheet, undated, revealed she was admitted to the facility on [DATE] with diagnosis of Vascular Dementia unspecified. Further review revealed she had family members who were designated as emergency contacts. Review of Resident #45's consent for the use of side rails, dated 5/30/23, was not signed by a family member. Observation on 09/10/24 at 1:30 PM revealed Resident #45 was lying in bed with two side rails up. Interview on 9/13/24 at 4:11 PM with LVN A revealed the admitting nurse typically had the Resident's family member sign the consent for the use of side rails. Interview on 9/13/24 at 5:30 PM with the RN Consultant revealed the admitting nurse was responsible for ensuring the family member signed the consent for Resident's use of side rails otherwise the Resident could not use the side rails. The RN Consultant stated staff was to make sure all resident documents were accurate and all areas were completed as required.		