STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676402	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windemere at Westover Hills	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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles for 3 of 5 medication carts (the 100/300 hall medication aide cart, the 100/300/400 hall nurse cart, and the 700 hall nurse cart) assessed for medication storage and labeling. The facility failed to ensure medications located inside the 100/300 hall medication aide cart, the 100/300/400 hall nurse cart, and the 700 hall nurse cart were stored in properly labeled containers. This failure could place residents at risk of receiving inadequate treatments or ingesting medications for which they were not prescribed. The findings included: During an observation of the 700 hall nurse cart on 12/17/2025 at 9:30 AM, an accessed insulin vial was discovered in the cart with no date of removal from refrigeration. During an interview with LVN A on 12/17/2025 at 9:30 AM, LVN A stated if an insulin vial did not have an opened date, the vial could be past the 28 days at room temperature period and be expired. LVN A further stated an undated vial should not be used because it would be unknown if the medication was still effective and would have the desired outcome for the resident. LVN A went on to state the pharmacy would be contacted to determine the fill date of the insulin and if the fill date was beyond 28 days, the vial would be discarded. During an observation of the 100/300 hall medication aide cart on 12/17/2025 at 9:47 AM, two pills were discovered unlabeled, lying in the bottom of the drawer. During an interview with Medication Aide B on 12/17/2025 at 9:47 AM, Medication Aide B stated loose pills should not be in the medication carts, because if a pill was laying in the drawer unlabeled, it would not be known what the pill was. Medication Aide B went on to state that even if a loose pill could be identified, it could not be administered to a resident because it would be unknown for whom it was prescribed. During an observation of the 100/300/400 nurse cart on 12/17/2025 at 11:55 AM, an accessed insulin vial was discovered in the cart with no date of removal from refrigeration, and four pills were found unlabeled, lying in the bottom of the drawer. During an interview with LVN C on 12/17/2025 at 11:55 AM, LVN C stated it was important for the opened date to be documented on the insulin vial, because it was only good for 28 days. LVN C went on to state that if the insulin was expired, it did not work the same. Regarding the loose pills discovered in the cart drawer, LVN C stated if loose pill were left in the medication cart, someone could accidentally take them. LVN C further stated the unlabeled pills could not be administered to any resident, because they would not know what the pill was or to whom it belonged. During an interview with the acting DON on 12/18/25 at 1:10 PM, the acting DON stated her expectation for medication carts was that they were clean and divided properly, that medications were dated, and that there were no expired medications. The acting DON further stated it was important for insulins to be dated, because they did not want expired medications to prevent any errors. The acting DON stated they did not want to give residents expired medications, because there could be an adverse effect, the medication might not be effective, nor treat the condition for which they were ordered. The acting DON stated insulins should be dated any time they were in the cart and as soon as they were taken out of the refrigerator. The acting DON stated if insulins were undated, they did not know how long they had been out of the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	refrigerator, and they could lose their efficacy. Regarding loose pills in the medication carts, the acting DON stated her expectation was for staff to make sure all pills were properly labeled. The acting DON further stated the importance of properly labeled medications was so they could ensure the correct medication was given to the right resident. The acting DON stated there should never be a pill in the cart not labeled, because they would not know to whom the pill belonged. The acting DON went on to state loose pills should be disposed of, and every cart should have a drug buster for disposal. Record review of the facility's policy titled Labeling of Medications and Biologicals dated 11/1/2025 noted All medications and biologicals used in the facility will be labeled in accordance with current state and federal regulations to facilitate consideration of precautions and safe administration of medications, .All medications and biologicals will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices, .Labels for individual drug containers must include: h. The expiration date when applicable, .Labels for multi-use vials must include: a. The date the vial was initially opened or accessed (needle-punctured); b. All opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. c. Unopened or unaccessed (needle-punctured) vials should be discarded according to the manufacturer's expiration date.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 2 of 8 residents (Resident #113, and Resident #16) reviewed for accidents and hazards: 1. The facility failed to ensure Resident #113 did not have a can of disinfectant spray and a plastic pump spray bottle of air freshener in her room. 2. The facility failed to ensure Resident #16 did not have two pairs of scissors in her room.These failures could place residents at risk of harm or injury and contribute to avoidable accidents and a decline in health.The findings included:1. Record review of Resident #113's face sheet dated 12/18/25 revealed an [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included history of falling, symptoms and signs involving cognitive function and awareness, repeated falls, need for assistance with personal care, lack of coordination, and dementia. Record review of Resident #113's most recent quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills.Record review of Resident #113's comprehensive care plan with revision date 9/29/25 revealed the resident was non-compliant with safety precautions and at risk for complications with interventions that included providing the resident with opportunities for choice during care provision.During an observation on 12/16/25 at 10:08 a.m. Resident #113 was observed with a can of disinfectant spray and a plastic pump spray bottle of air freshener next to the sink in the resident's room. During an observation on 12/18/25 at 11:37 a.m. Resident #113 was observed with a plastic pump spray bottle of air freshener next to the sink in the resident's room.2. Record review of Resident #16's face sheet dated 12/18/25 revealed a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included dry eyes, history of falling, difficulty in walking, lack of coordination, and syncope (fainting) and collapse (refers to a sudden, temporary loss of consciousness caused by a brief reduction in blood flow to the brain followed by a fall or collapse).Record review of Resident #16's most recent quarterly MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills.Record review of Resident #16's comprehensive care plan with revision date 6/22/25 revealed the resident was non-compliant with safety precautions and interventions included to encourage as much participation/interaction by the resident as possible during care activities. Resident #16's comprehensive care plan revealed the resident was at risk for impaired visual function related to dry eyes and wore glasses, with interventions that included to monitor/document/report signs and symptoms of acute eye problems.During an observation and interview on 12/16/25 at 10:26 a.m., Resident #16 was observed with a pair of pink handle scissors on a small table next to where the resident was seated in a chair and a pair of black handle scissors on a small desk at the foot of the bed. Resident #16 stated the pink handle scissors were used to open her condiments and the black handle scissors were used to open boxes and packages. During an observation on 12/18/25 at 11:32 a.m., Resident #16 was observed with a pair of pink handle scissors on a small table next to the resident's bed and a pair of black handle scissors on a small desk at the foot of the bed. During an observation and interview on 12/18/25 at 11:46 a.m., CNA E stated, Resident #16 was not supposed to have scissors in the room and there were items residents in the facility were not allowed to have. CNA E stated items such as scissors, nail clippers, and aerosol sprays weren't supposed to be in resident rooms due to safety concerns. CNA E stated there were residents in the facility who wandered and could gain access to those items and hurt themselves. CNA E stated the CNA staff were responsible for making rounds of resident rooms and if items such as scissors were found they were supposed to report it to the nurse.During an observation and interview on 12/18/25 at 11:53 a.m., LVN F observed Resident #16 with a pair of pink handle scissors and a pair of black handle scissors in the resident's room. LVN F stated Resident #16 was not supposed to have scissors in her (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room because the resident could drop them, have a fall, and cut herself, or somebody else could grab them. LVN F stated she usually went into the resident's room to provide care or obtain vital signs and if she had seen the scissors she would have had to confiscate them for safety reasons. During an observation and interview on 12/18/25 at 11:57 a.m., Resident #113 stated she used the plastic pump spray bottle of air freshener to make her room smell good, and she had thrown out the can of disinfectant spray because she used it up. Observation with CNA E revealed the plastic pump spray bottle in Resident #113's room was not supposed to be in there because it could be used improperly and LVN E stated chemicals, and sharp objects were prohibited from being in a resident's room due to safety concerns. During an interview on 12/18/25 at 1:20 p.m., the Acting DON stated items such as scissors, aerosol cans, and pump sprays which had a label that indicated keeping away from children were prohibited in the resident rooms. The Acting DON stated it was her understanding that residents who were alert and oriented were allowed to keep items such as scissors, but required it be care planned. The Acting DON stated the items discussed could be a potential for an injury or somebody could walk into the room and pick them up which could also lead to potential injury. The Acting DON stated it was a facility wide thing and all staff should be aware of and the expectation of what we could and could not allow in the rooms. The Acting DON stated it was the responsibility of all departments to report and communicate to the nursing staff and supervisors items not allowed in the residents' rooms. During an interview on 12/18/25 at 2:44 p.m., the Administrator stated residents were not allowed to have scissors, aerosol cans or pump sprays in their rooms because it was best practice. The Administrator stated the facility provided a list of prohibited items to the residents or family upon admission.The facility did not provide a policy regarding prohibited items at the time of the exit on 12/19/25.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care is provided with such care, consistent with professional standards of practice for 2 of 4 residents (Resident #7, and #29) reviewed for respiratory care.1. The facility failed to ensure Resident #7's oxygen concentrator filter was cleaned and free of debris.2. The facility failed to ensure Resident #29's oxygen concentrator filter was cleaned and free of debris, the oxygen tubing was touching the floor, and the oxygen flow rate was set according to the physician's ordersThese deficient practices could place residents at risk for an increase in respiratory complications. The findings included:1. Record review of Resident #7's face sheet dated 12/17/25 reflected an [AGE] year-old female admitted to the facility on [DATE], and re-admitted on [DATE] with diagnoses that included aftercare following joint replacement surgery, chronic obstructive pulmonary disease (a long-term, progressive lung disease that makes it difficult to breathe due to airflow obstruction that is not fully reversible), need for assistance with personal care, cough, shortness of breath, lack of coordination, and heart failure. Record review of Resident #7's most recent comprehensive MDS assessment dated [DATE] reflected the resident was cognitively intact for daily decision-making skills, was dependent on staff for mobility and transfers, and required oxygen therapy. Record review of Resident #7's comprehensive care plan with revision date 12/8/25 reflected the resident used supplemental oxygen and was at risk for complications with interventions that included to give medications as ordered by the physician, and provide oxygen as ordered. Record review of Resident #7's Order Summary Report dated 12/17/25 reflected the following:- Oxygen at 2-4 L per minute via nasal cannula as needed with order date 12/15/25 and no end date.- Oxygen tubing and humidifier change every night shift every Sunday with order date 3/30/25 and no end date. During an interview and observation on 12/17/25 at 7:57 a.m. Resident #7 was observed with the oxygen concentrator operating via a nasal cannula at 2 LPM. Resident #7's oxygen concentrator had a filter in the back that appeared to have a layer of built-up lint/dust. Resident #7 stated nursing staff handled the oxygen concentrator because she was unable to get out of bed. During an observation on 12/18/25 at 8:02 a.m. revealed Resident #7 was in bed with the oxygen concentrator operating via the nasal cannula. Resident #7's oxygen concentrator had a filter in the back that appeared to have a layer of built-up lint/dust. During an observation and interview on 12/18/25 at 8:07 a.m. LVN F revealed nursing staff were responsible for setting up and changing the tubing and humidifier bottle on the oxygen concentrators. LVN F stated, while she was scheduled to be on duty, she would change out the tubing with the nasal cannula at least every two days because the cannula could get dirty and was responsible to ensure the liters of oxygen was set according to physician's orders. LVN F stated she did not know the oxygen concentrator had a filter and did not know where it was located. LVN F removed the oxygen filter from behind Resident 7's concentrator and stated, it's dirty. LVN F stated, the oxygen filter appeared to be covered in dust and stated, Resident #7 was breathing that (the dust). LVN F stated Resident #7 had breathing issues and the dirty filter could cause the resident to develop an infection. LVN F stated Resident #7 used the oxygen concentrator continuously. 2. Record review of Resident #29's face sheet dated 12/18/25 reflected a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (a long-term, progressive lung disease that makes it difficult to breathe due to airflow obstruction that is not fully reversible), need for assistance with personal care, allergic rhinitis (an inflammation of the lining of the nose caused by an allergic reaction to airborne substances such as pollen, dust mites, mold, or pet dander), wheezing (a high-pitched, whistling sound heard during breathing, usually when air flow through narrowed or partially blocked airways), difficulty in walking, and shortness of breath. Record review of Resident #29's most recent quarterly MDS assessment dated [DATE] reflected the resident was moderately cognitively impaired for daily (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	decision-making skills, was dependent on staff for mobility and transfers, and required oxygen therapy. Record review of Resident #29's comprehensive care plan with revision date 12/12/25 reflected the resident was treated with oxygen related to chronic obstructive pulmonary disease and was at risk for complications with interventions that included to give medications ordered by the physician, and provide oxygen as ordered. Record review of Resident #29's Order Summary Report dated 12/18/25 reflected the following:- Oxygen at 2-4 L per minute via nasal cannula to keep oxygen saturation above 90% as needed related to chronic obstructive pulmonary disease with order date 12/15/25 and no end date.- Oxygen tubing and humidifier change every night shift every Sunday with order date 8/18/25 and no end date. During an observation and interview on 12/18/25 at 7:43 a.m., Resident #29 stated the oxygen concentrator tubing was changed by nursing every Sunday night. Resident #29 was observed with the oxygen concentrator operating via the nasal cannula at 0.5 LPM. Resident #29's oxygen tubing connected to the concentrator was observed touching the floor, and the filter on the back of the concentrator appeared to have a layer of built-up lint/dust. Resident #29 stated she did not touch the oxygen concentrator because she was unable to reach the unit. Resident #29 stated she was treated with oxygen consistently since she was re-admitted from the hospital (8/11/25). During an observation and interview on 12/18/25 at 7:50 a.m., LVN G stated Resident #29 was treated with oxygen as needed. LVN G stated the nursing staff were responsible for setting up and changing the tubing and humidifier bottle on the oxygen concentrators. LVN G stated she changed out the tubing and humidifier bottle on Sunday (12/14/25) but had not changed Resident #29's oxygen filter as it was done once a month. LVN G observed Resident #29's oxygen tubing touching the floor but was not sure if that was a problem and would not know how to keep it off the floor. LVN G stated Resident #29's oxygen filter looked like it had dust on it and should not be that way. LVN G observed Resident #29's oxygen level setting and stated it was not supposed to be set at 0.5 LPM but should be set from 2 LPM to 5 LPM and did not know why it was set that way. LVN G stated the setting could not have been changed by Resident #29 because the resident was not able to get to it. LVN G stated the dust on the oxygen filter was getting into the resident's lungs and the oxygen setting below orders meant the resident could develop a respiratory infection and the resident already had compromised lungs.During an interview on 12/18/25 at 1:20 p.m., the Acting DON stated it was her expectation for the nursing staff to ensure they checked the oxygen concentrator settings, filters and tubing. The Acting DON stated the oxygen settings should be checked every shift to reflect they were set by the physician's orders. The Acting DON stated the end of the oxygen tubing such as the cannula and the opposite end of the tubing connected to the concentrator were not supposed to be touching the floor but was not sure about the excess tubing touching the floor and would have to check the facility policy. The Acting DON stated nursing was responsible for checking the filters on the oxygen concentrators to ensure they were clean and if not, they were supposed to be changed out. The Acting DON stated dirty oxygen filters could cause respiratory issues and since dust had particles they could be inhaled by the resident and could cause a respiratory infection. Record review of the facility's policy titled Oxygen Concentrator dated 11/1/25 reflected in part, .The purpose of this policy is to establish responsibilities for the care and use of oxygen concentrators.An ?oxygen concentrator' is a medical device that extracts oxygen from room air.Oxygen is administered under orders of the attending physician.The nurse shall verify physician's orders for the rate of flow and route of administration of oxygen.Follow manufacturer recommendations for the frequency of cleaning filters.Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled for 1 of 5 carts (500 hall nurse cart) reviewed for pharmacy services. The facility failed to ensure the controlled substance reconciliation log was signed for accuracy of medication quantities during shift change. This failure could place residents at risk of not receiving their prescribed medications, experiencing untreated pain and anxiety, and a decreased quality of life. The findings included: During an observation of the 500 hall nurse cart on 12/18/2025 at 8:40 AM, a sample of controlled medications was inventoried for accuracy with LVN D. The sample inventory showed no discrepancies between medication quantities documented on the individual controlled substance logs and the number of pills remaining in the blister packs. However, record review of the comprehensive controlled medication reconciliation log used for the cart audit during shift change revealed the log was missing a signature. During an interview with LVN D on 12/18/2025 at 8:40 AM, LVN D stated it was important for the controlled medication reconciliation log to be signed at each shift change with the oncoming or off going staff member to document that the count of the controlled medications was accurate. LVN D further stated it was necessary to sign the reconciliation log, so she did not get blamed for something another staff member did. During an interview with the acting DON on 12/18/25 at 1:10 PM, the acting DON stated her expectation for the controlled medication reconciliation logs was that the logs should be signed off every time staff members counted controlled medications between shift changes. The acting DON further stated it was important for the logs to be signed each shift to ensure the counts of controlled medications were correct and there were no diversions. The DON went on to state if the log is missing signatures, it made it hard because they only have the last signature to go off, and a medication could have been given to the wrong resident or be lost. Record review of the facility's policy titled Controlled Substance Administration & Accountability dated 11/1/25, noted It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure, .Inventory Verification: b. For areas without automated dispensing systems, two licensed nurses account for all controlled substances and access keys at the end of each shift.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the residents' clinical record was complete and accurate for 1 (Resident #130) of 25 residents reviewed, in that: Resident #130's diagnoses of Insomnia and Dementia were not present on the resident's diagnoses list. This deficient practice could result in delayed or improper care due to inaccurate clinical records. The findings were:Record review of Resident #130's face sheet, dated 12/18/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses including Acute respiratory failure with hypoxia, Acute kidney failure, and Muscle weakness. Record review of Resident #130's admission MDS, dated [DATE], revealed a BIMS score of 7 which indicated severe cognitive impairment. Record review of Resident #130's care plan, revised 07/25/2025, revealed [Resident #130] is resistive to care and medications. Record review of Resident #130's clinical record revealed a psychiatric provider note, date 09/22/2025, Tertiary Treating Dx: F51.02 - Adjustment insomnia. Dx Treating 4: F02.B3 - Dementia in other diseases classified elsewhere, moderate, with mood disturbance. Record review of Resident #130's clinical record revealed an order, dated 09/01/2025, Order Summary: Melatonin Oral Tablet 3 MG Give 3 tablet by mouth at bedtime for insomnia. Further review revealed an order, dated 09/22/2025, Order Summary: Aricept Oral Tablet 5 MG (Donepezil Hydrochloride) Give 1 tablet by mouth at bedtime for dementia. Further review of Resident #130's clinical record revealed the diagnoses of Insomnia and Dementia were not among the listed diagnoses and therefore did not populate on the resident's face sheet. During an interview with RN/MDS H on 12/18/2025 at 3:35 p.m., RN/MDS H confirmed Resident #130's diagnoses of Insomnia and Dementia were not included in the diagnosis list and therefore did not populate on the resident's face sheet. RN/MDS H confirmed the resident's diagnoses list, care plan, and physician orders should be uniform, and stated it was important for providers and clinicians to have an accurate understanding of the residents' health status. RN/MDS H confirmed that hospitals and other providers outside of the facility relied upon the resident face sheet for information about the residents' health status. During an interview with the Administrator on 12/19/2025 at 8:30 a.m., the Administrator confirmed the resident's diagnoses list, care plan, and physician orders should be uniform, and stated it was important for providers and clinicians to have an accurate understanding of the residents' health status. Record review of the facility policy, Documentation in Medical Record, dated 11/01/2025, revealed, Each resident's medical record shall contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.