STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676425	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Enclave	18803 Hardy Oak San Antonio, TX 78258

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the residents were free from abuse for 1 of 4 residents (Resident #1) reviewed for freedom from abuse. Resident #1 was kissed and touched by CNA A and it was recorded on the camera in her room.This failure could place residents at risk of abuse, neglect, and exploitation.The findings were:Record review of Resident #1's face sheet dated 2/6/26 revealed the resident was a [AGE] year-old female admitted on [DATE] with readmission on [DATE]. Resident #1's diagnoses included vascular dementia, moderate with anxiety (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain and include anxiety), memory deficit following cerebral infarction (issues with memory following a stroke), hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (weakness and loss of strength on one side of the body), and generalized anxiety disorder (excessive, ongoing anxiety and worry that interferes with daily activities).Record review of Resident #1's quarterly MDS dated [DATE] revealed the resident had minimal difficulty hearing, was usually understood and usually understands others and had clear speech. The resident had a BIMS of 11 of 15 indicating the resident was moderately cognitively impaired. The resident did not have any verbal or physical behaviors, had impairment to upper and lower extremities on one side of her body, and used a manual wheelchair. The resident was Dependent - Helper does all of the effort. Resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity for toileting transfer and toileting hygiene. The resident was Substantial/maximal assistance - Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. For lying to sitting, transfers, and showers. And the resident was frequently incontinent of bowel and bladder.Record review of Resident #1's Care plan dated 2/6/26 revealed a focus initiated on 3/21/25 and revised on 3/28/25 for memory problems that may affect ability to communicate her needs and wants and forgetfulness with interventions to anticipate her needs, engage in conversations, give time to respond. Another focus initiated on 5/4/25 for problems communicating her needs and wants due to cognitive impairment with the same interventions as previously stated above. Another focus initiated on 3/20/25 and revised on 2/6/26 for being at risk of emotional distress or behaviors and being forgetful, confused, combative and agitated with interventions to reassure the resident she is safe dated 3/20/25, report sadness, crying, wishes to harm self or others dated 12/24/25, risk monitoring on-going. Monitor for any emotional issues and/ or behaviors. Attempt to calm the resident by speaking in a calm tone and reassure the person's safety no date initiated.Record review of the facility investigation regarding CNA A's actions toward Resident #1 dated 12/22/25 revealed an ADHOC was held with the Administrator, DON, and Medical Director for a concern regarding unprofessional conduct. The resident was assessed with no negative findings. The Administrator validated that Resident #1 verbally denied being abused physically or (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sexually and was monitored following the report of an unprofessional gesture made by a caregiver. CNA A was interviewed and stated he felt compassion for Resident #1 as he did with his own mother and the resident had been crying and was emotional regarding her family member not visiting and he was only trying to console Resident #1 and offer compassion. CNA A stated he needed to go PRN status immediately. The RP was notified on 12/22/25. Resident #1 would continue to be monitored to ensure she continued to have no concerns of abuse and no emotional distress. Resident #1 felt safe and care for by all staff. CNA A was removed from the schedule until interview and retraining completed with administration and reeducation provided regarding 1. Providing compassionate care in a professional manner. 2. Professional conduct and expectations. 3. Identifying, preventing, protecting against and reporting ANE. 4. Resident dignity and rights. 5. Texas HHSC provider letter regarding reportable incidents 6. Updating the plan of care, ensuring that appropriate interventions are in place. 7. Ensure that appropriate interventions are noted on the plan of care as well as the Kardex. 8. Educating staff on intervention such as specific monitoring and interventions and the comprehensive care plan process. All current residents assessed to validate safety and well-being. No negative outcomes identified.Record review of the facility investigation regarding CNA A's actions toward Resident #1 revealed a resident interview dated 12/23/25 with Resident #1. Question #1 - Tell me how you are doing today and handwritten was OK. Question #2 - Tell me how you are being treated here and handwritten was OK. Question #3 - Tell me how care givers speak to you and handwritten was OK. Question #5 - tell me if you have seen anyone treating another resident in a rough manner, in an inappropriate manner or an unkindly manner. Explain, have you ever been treated in a rough manner or unkindly? Handwritten was the resident's response Yes, some man kissed me and touched me. Review of a video provided to the surveyor with file name Ring_Resident#1's first name_20251221_1032 revealed an MP4 video with date and time on the lower right. The video ran from 12/21/25 at 10:32 a.m. to 10:34 a.m. in the resident's room. The video evidence revealed the resident was in bed covered with blankets and a white blanket rolled or bunched up on her chest. CNA A was seated in a chair pulled up next to the left side of Resident #1's bed. CNA A was leaning on his left elbow and arm against the mattress and his right arm from his hand to his elbow appeared to be under the resident's blanket near her chest. The resident's head and face were turned to the right slightly and facing away from CNA A. CNA A was speaking to Resident #1 but the surveyor was unable to hear most of what was being said. The resident was replying as well but the surveyor was unable to understand what was said. The resident's left foot was moving under the blankets during the conversation. CNA A then stood up and leaned over the resident, bending his head, and appeared to kiss the resident near her head but unable to see where on the video as his back was to the camera but a kissing sound could be heard and then CNA A sat back down in the chair and was leaning on his left elbow on the mattress and rested his chin in his left hand and his right hand and arm remained under the resident's blankets at her chest. CNA A began telling the resident that he brought her breakfast and she did not call to be changed or anything so he thought he would check on her. The resident turned her head to face CNA A during that time and Resident #1 asked what was for breakfast and CNA A got up and walked around to the right side of her bed and examined her breakfast, telling her what it was. The resident stated she gets tired of the heavy stuff. CNA A then touched the resident's right upper arm and asked if he could use her bathroom and she said he could. CNA A attempted to close the sliding door to the resident's bathroom but was unable to fully close it and walked to the toilet which could be partially seen in the video and then the video ended.Review of a video with file name Ring_Resident#1's first name_20251221_1037 revealed an MP4 video with a date and time on the lower right. The video ran from 12/21/25 at 10:37 a.m. to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10:38 a.m. in the resident's room. The video evidence revealed the resident remained in bed and was covered with blankets from her waist down. CNA A was standing on the right side of the resident's bed and holding her right hand with his right hand and covering her hand with his left hand. CNA A removed his left hand and leaned down and kissed the resident just to the right side of her mouth and the resident stated, Thank you. CNA A stood back up and was still holding the resident's right hand in his right hand and covered it again with his left hand and looked away from the resident's face and then again released his left hand that was covering their hands and leaned down and kissed the resident on her mouth. The resident smiled and made a pecking kissing sound. CNA A stood back up and covered their hands again with his left and stated, I like you. CNA A then began to cover up the resident while still holding her right hand in his right hand and asked the resident if she wanted him to let her sleep or if she wanted him to visit her and the resident stated she wanted to sleep. CNA A caressed the right side of the resident's face with the back of his left hand and fingers several times and told the resident he would come back and check on her. The resident then apologized and CNA A laughed and stated, It's ok. CNA A finished covering the resident up and moved her call light and bedside table within reach and told the resident he would check on the other residents and make his way back to her probably about lunch time. The resident then stated, And your name is [CNA A's first name]. and he replied it was and the resident stated, And you're a nurse. and CNA A replied that he was and asked the resident Is that okay? and the resident stated it was. CNA A stated he had Resident #1's hall today. CNA A then left the room and shut the door.Record review of CNA A's employee file revealed background checks were completed 9-25-25 and 9-29-25. The competency checklist included privacy, dignity, resident rights, and abuse and neglect were completed on 10/14/25. The competency was met for knowledge of abuse and neglect, and what constituted abuse and neglect and reporting and was signed by the DON. There was a disciplinary action with date of policy violation 12/27/25 by the DON and Administrator. Under summary of violation was typed Rude, disrespectful, or unprofessional behavior to other team members, supervisors, residents, family members or visitors including failure to treat all with kindness, respect, and dignity. Category 1 violation at a level of written coaching to maintain professional boundaries at all times with staff, residents, family members and or visitors. further disciplinary action and or termination. It was signed by CNA A and the DON on 12/22/25. Review of the facility time sheets for December 2025 revealed CNA A worked on 12/21/25 from 6:11 a.m. to 2:26 p.m. and on 12/22/26 7:46 a.m. to 8:53 a.m.; no further shifts were worked at the facility after 12/22/25.In an interview on 2/4/26 at 4:45 p.m. with the Administrator and the DON, the Administrator stated there were previous allegations about inappropriate touching with another resident but it was unsubstantiated . The Administrator further stated there was an incident where CNA A was holding Resident #1's hand but that the resident and her family member both denied any allegation. The Administrator stated CNA A was taking care of his own mother and went PRN and then resigned but it was not related to the current incident. The DON stated the incident was not reported to HHSC as there was no allegation made and the resident felt safe and stated she would still let CNA A care for her. The Administrator stated they had not seen a video where CNA A was sitting next to the resident's bed with his hand covered by blankets. The Administrator and DON stated CNA A was trying to console the resident when he kissed her on her cheek and that it was unprofessional conduct but not reportable. The Administrator and DON stated they were sent one video and the resident and the resident's family member had no concerns or issues. The Administrator stated CNA A did not work at the facility since the incident on 12/21/25. The DON stated the resident's family member was fine with CNA A not working with the resident anymore and had no other concerns. In an observation and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 2/4/26 at 5:30 p.m. revealed Resident #1 was resting in bed. The resident stated she did have an incident with a staff member and the facility staff talked to her about it. Resident #1 stated she was told by administration that CNA A was only trying to console her because she was sad. Resident #1 then turned her head towards the surveyor and motioned with her hand pointing to herself and stated, I didn't know I was sad. Resident #1 then stated CNA A was related to someone around here, not sure who but he's someone's nephew I think. Resident #1 then denied CNA A touched her and denied being kissed on the mouth. The resident stated CNA A did kiss her on the forehead. The resident then stated, I didn't feel threatened though. Resident #1 stated it made her feel surprised as she did not think anyone would want to kiss her at her age. In an interview on 2/5/26 at 11:15 a.m. the DON stated there was no allegation made by Resident #1 or her family member and they were sent the video because the family member wanted to know who CNA A was but that there were no concerns or allegations made. The DON stated the video did not show abuse or exploitation of the resident and only showed unprofessional conduct and was not reportable as no allegation was made by the resident or family member and the resident felt safe. In an anonymous interview, and record review, it was stated Resident #1 had stated that CNA A had kissed her and that prompted checking the video camera in her room. The video with CNA A kissing Resident #1 and sitting next to her bed with his hand not viewable under the blankets was sent to the Administrator and the DON via email. Review of the email revealed it was sent to the Administrator and DON on 12/22/25 at 10:30 a.m. The DON had responded that they had received the video and would be addressing the issue. Interview further revealed the facility had terminated CNA A or that was the assumption as they were told CNA A was no longer employed at the facility but not sure on the date , they were told that. In a telephone interview on 2/5/26 at 3:09 p.m. CNA A stated he remembered Resident #1. CNA A stated he had gone in to check on the resident and he asked if he could check her and she said yes, he did and then the resident started to cry and said she just wanted to die. She said her family member forgot about her, she wanted to kill herself and the resident asked if she could get a hug and he hugged her. The next time he sat down with her and she was saying the same things. CNA A stated the resident's statements of wanting to kill herself and being so lonely and her family member forgetting about her were reported to the charge nurse and to the Administrator . CNA A stated that he hugged Resident #1 and kissed her on the cheek but it was kind of mutual. CNA A denied kissing the resident on her lips or being inappropriate .Review of the facility policy for abuse guidance: preventing, identifying, and reporting revised January 2024 indicated Every resident has the right to be free from abuse, neglect. Residents should not be subjected to abuse by anyone, including to but not limited to community team members, other residents, consultants. All alleged/suspected violations and all substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities. as may be required by law and per the current state/federal reporting requirements. sexual abuse is defined at 483.5 as non-consensual sexual contact of any type with a resident. Willful is defined at 483.5 in the definition of abuse and means the individual should have acted deliberately, not that the individual should have intended to inflict injury or harm.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 4 residents (Resident #1) reviewed for freedom from abuse, neglect, and exploitation.The facility failed to report to HHSC that Resident #1 was kissed and touched by CNA A. This failure could place residents at risk of unidentified and on-going abuse, neglect, and exploitation. The findings were:Record review of Resident #1's face sheet dated 2/6/26 revealed the resident was a [AGE] year-old female admitted on [DATE] with readmission on [DATE]. Resident #1's diagnoses included vascular dementia, moderate with anxiety (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain and include anxiety), memory deficit following cerebral infarction (issues with memory following a stroke), hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (weakness and loss of strength on one side of the body), and generalized anxiety disorder (excessive, ongoing anxiety and worry that interferes with daily activities).Record review of Resident #1's quarterly MDS dated [DATE] revealed the resident had minimal difficulty hearing, was usually understood and usually understands others and had clear speech. The resident had a BIMS of 11 of 15 indicating the resident was moderately cognitively impaired. The resident did not have any verbal or physical behaviors, had impairment to upper and lower extremities on one side of her body, and used a manual wheelchair. The resident was Dependent - Helper does all of the effort. Resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity for toileting transfer and toileting hygiene. The resident was Substantial/maximal assistance - Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. For lying to sitting, transfers, and showers. And the resident was frequently incontinent of bowel and bladder.Record review of Resident #1's Care plan dated 2/6/26 revealed a focus initiated on 3/21/25 and revised on 3/28/25 for memory problems that may affect ability to communicate her needs and wants and forgetfulness with interventions to anticipate her needs, engage in conversations, give time to respond. Another focus initiated on 5/4/25 for problems communicating her needs and wants due to cognitive impairment with the same interventions as previously stated above. Another focus initiated on 3/20/25 and revised on 2/6/26 for being at risk of emotional distress or behaviors and being forgetful, confused, combative and agitated with interventions to reassure the resident she is safe dated 3/20/25, report sadness, crying, wishes to harm self or others dated 12/24/25, risk monitoring on-going. Monitor for any emotional issues and/ or behaviors. Attempt to calm the resident by speaking in a calm tone and reassure the person's safety no date initiated.Record review of the facility investigation regarding CNA A's actions toward Resident #1 dated 12/22/25 revealed an ADHOC was held with the Administrator, DON, and Medical Director for a concern regarding unprofessional conduct. The resident was assessed with no negative findings. The Administrator validated that Resident #1 verbally denied being abused physically or sexually and was monitored following the report of an unprofessional gesture made by a caregiver. CNA A was interviewed and stated he felt compassion for Resident #1 as he did with his own mother and the resident had been crying and was emotional regarding her family member not visiting and he was only trying to console Resident #1 and offer compassion. CNA A (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated he needed to go PRN status immediately. The RP was notified on 12/22/25. Resident #1 would continue to be monitored to ensure she continued to have no concerns of abuse and no emotional distress. Resident #1 felt safe and care for by all staff. CNA A was removed from the schedule until interview and retraining completed with administration and reeducation provided regarding 1. Providing compassionate care in a professional manner. 2. Professional conduct and expectations. 3. Identifying, preventing, protecting against and reporting ANE. 4. Resident dignity and rights. 5. Texas HHSC provider letter regarding reportable incidents 6. Updating the plan of care, ensuring that appropriate interventions are in place. 7. Ensure that appropriate interventions are noted on the plan of care as well as the Kardex. 8. Educating staff on intervention such as specific monitoring and interventions and the comprehensive care plan process. All current residents assessed to validate safety and well-being. No negative outcomes identified.Record review of the facility investigation regarding CNA A's actions toward Resident #1 revealed a resident interview dated 12/23/25 with Resident #1. Question #1 - Tell me how you are doing today and handwritten was OK. Question #2 - Tell me how you are being treated here and handwritten was OK. Question #3 - Tell me how care givers speak to you and handwritten was OK. Question #5 - tell me if you have seen anyone treating another resident in a rough manner, in an inappropriate manner or an unkindly manner. Explain, have you ever been treated in a rough manner or unkindly? Handwritten was the resident's response Yes, some man kissed me and touched me. Review of a video provided to the surveyor with file name Ring_Resident#1's first name_20251221_1032 revealed an MP4 video with date and time on the lower right. The video ran from 12/21/25 at 10:32 a.m. to 10:34 a.m. in the resident's room. The video evidence revealed the resident was in bed covered with blankets and a white blanket rolled or bunched up on her chest. CNA A was seated in a chair pulled up next to the left side of Resident #1's bed. CNA A was leaning on his left elbow and arm against the mattress and his right arm from his hand to his elbow appeared to be under the resident's blanket near her chest. The resident's head and face were turned to the right slightly and facing away from CNA A. CNA A was speaking to Resident #1 but the surveyor was unable to hear most of what was being said. The resident was replying as well but the surveyor was unable to understand what was said. The resident's left foot was moving under the blankets during the conversation. CNA A then stood up and leaned over the resident, bending his head, and appeared to kiss the resident near her head but unable to see where on the video as his back was to the camera but a kissing sound could be heard and then CNA A sat back down in the chair and was leaning on his left elbow on the mattress and rested his chin in his left hand and his right hand and arm remained under the resident's blankets at her chest. CNA A began telling the resident that he brought her breakfast and she did not call to be changed or anything so he thought he would check on her. The resident turned her head to face CNA A during that time and Resident #1 asked what was for breakfast and CNA A got up and walked around to the right side of her bed and examined her breakfast, telling her what it was. The resident stated she gets tired of the heavy stuff. CNA A then touched the resident's right upper arm and asked if he could use her bathroom and she said he could. CNA A attempted to close the sliding door to the resident's bathroom but was unable to fully close it and walked to the toilet which could be partially seen in the video and then the video ended.Review of a video with file name Ring_Resident#1's first name_20251221_1037 revealed an MP4 video with a date and time on the lower right. The video ran from 12/21/25 at 10:37 a.m. to 10:38 a.m. in the resident's room. The video evidence revealed the resident remained in bed and was covered with blankets from her waist down. CNA A was standing on the right side of the resident's bed and holding her right hand with his right hand and covering her hand with his left hand. CNA A removed his left hand and leaned down and kissed the resident just to (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the right side of her mouth and the resident stated, Thank you. CNA A stood back up and was still holding the resident's right hand in his right hand and covered it again with his left hand and looked away from the resident's face and then again released his left hand that was covering their hands and leaned down and kissed the resident on her mouth. The resident smiled and made a pecking kissing sound. CNA A stood back up and covered their hands again with his left and stated, I like you. CNA A then began to cover up the resident while still holding her right hand in his right hand and asked the resident if she wanted him to let her sleep or if she wanted him to visit her and the resident stated she wanted to sleep. CNA A caressed the right side of the resident's face with the back of his left hand and fingers several times and told the resident he would come back and check on her. The resident then apologized and CNA A laughed and stated, It's ok. CNA A finished covering the resident up and moved her call light and bedside table within reach and told the resident he would check on the other residents and make his way back to her probably about lunch time. The resident then stated, And your name is [CNA A's first name]. and he replied it was and the resident stated, And you're a nurse. and CNA A replied that he was and asked the resident Is that okay? and the resident stated it was. CNA A stated he had Resident #1's hall today. CNA A then left the room and shut the door.Record review of CNA A's employee file revealed background checks were completed 9-25-25 and 9-29-25. The competency checklist included privacy, dignity, resident rights, and abuse and neglect were completed on 10/14/25. The competency was met for knowledge of abuse and neglect, and what constituted abuse and neglect and reporting and was signed by the DON. There was a disciplinary action with date of policy violation 12/27/25 by the DON and Administrator. Under summary of violation was typed Rude, disrespectful, or unprofessional behavior to other team members, supervisors, residents, family members or visitors including failure to treat all with kindness, respect, and dignity. Category 1 violation at a level of written coaching to maintain professional boundaries at all times with staff, residents, family members and or visitors. further disciplinary action and or termination. It was signed by CNA A and the DON on 12/22/25. Review of the facility time sheets for December 2025 revealed CNA A worked on 12/21/25 from 6:11 a.m. to 2:26 p.m. and on 12/22/26 7:46 a.m. to 8:53 a.m.; no further shifts were worked at the facility after 12/22/25.In an interview on 2/4/26 at 4:45 p.m. with the Administrator and the DON, the Administrator stated there were previous allegations about inappropriate touching with another resident but it was unsubstantiated . The Administrator further stated there was an incident where CNA A was holding Resident #1's hand but that the resident and her family member both denied any allegation. The Administrator stated CNA A was taking care of his own mother and went PRN and then resigned but it was not related to the current incident. The DON stated the incident was not reported to HHSC as there was no allegation made and the resident felt safe and stated she would still let CNA A care for her. The Administrator stated they had not seen a video where CNA A was sitting next to the resident's bed with his hand covered by blankets. The Administrator and DON stated CNA A was trying to console the resident when he kissed her on her cheek and that it was unprofessional conduct but not reportable. The Administrator and DON stated they were sent one video and the resident and the resident's family member had no concerns or issues. The Administrator stated CNA A did not work at the facility since the incident on 12/21/25. The DON stated the resident's family member was fine with CNA A not working with the resident anymore and had no other concerns. In an observation and interview on 2/4/26 at 5:30 p.m. revealed Resident #1 was resting in bed. The resident stated she did have an incident with a staff member and the facility staff talked to her about it. Resident #1 stated she was told by administration that CNA A was only trying to console her because she was sad. Resident #1 then turned her head towards the surveyor and motioned with her (continued on next page)

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The Enclave	18803 Hardy Oak San Antonio, TX 78258

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hand pointing to herself and stated, I didn't know I was sad. Resident #1 then stated CNA A was related to someone around here, not sure who but he's someone's nephew I think. Resident #1 then denied CNA A touched her and denied being kissed on the mouth. The resident stated CNA A did kiss her on the forehead. The resident then stated, I didn't feel threatened though. Resident #1 stated it made her feel surprised as she did not think anyone would want to kiss her at her age. In an interview on 2/5/26 at 11:15 a.m. the DON stated there was no allegation made by Resident #1 or her family member and they were sent the video because the family member wanted to know who CNA A was but that there were no concerns or allegations made. The DON stated the video did not show abuse or exploitation of the resident and only showed unprofessional conduct and was not reportable as no allegation was made by the resident or family member and the resident felt safe. In an anonymous interview, and record review, it was stated Resident #1 had stated that CNA A had kissed her and that prompted checking the video camera in her room. The video with CNA A kissing Resident #1 and sitting next to her bed with his hand not viewable under the blankets was sent to the Administrator and the DON via email. Review of the email revealed it was sent to the Administrator and DON on 12/22/25 at 10:30 a.m. The DON had responded that they had received the video and would be addressing the issue. Interview further revealed the facility had terminated CNA A or that was the assumption as they were told CNA A was no longer employed at the facility but not sure on the date , they were told that. In a telephone interview on 2/5/26 at 3:09 p.m. CNA A stated he remembered Resident #1. CNA A stated he had gone in to check on the resident and he asked if he could check her and she said yes, he did and then the resident started to cry and said she just wanted to die. She said her family member forgot about her, she wanted to kill herself and the resident asked if she could get a hug and he hugged her. The next time he sat down with her and she was saying the same things. CNA A stated the resident's statements of wanting to kill herself and being so lonely and her family member forgetting about her were reported to the charge nurse and to the Administrator . CNA A stated that he hugged Resident #1 and kissed her on the cheek but it was kind of mutual. CNA A denied kissing the resident on her lips or being inappropriate .Review of the facility policy for abuse guidance: preventing, identifying, and reporting revised January 2024 indicated Every resident has the right to be free from abuse, neglect. Residents should not be subjected to abuse by anyone, including to but not limited to community team members, other residents, consultants. All alleged/suspected violations and all substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities. as may be required by law and per the current state/federal reporting requirements. sexual abuse is defined at 483.5 as non-consensual sexual contact of any type with a resident. Willful is defined at 483.5 in the definition of abuse and means the individual should have acted deliberately, not that the individual should have intended to inflict injury or harm.