STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675002	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Antonio West Nursing and Rehabilitation	636 Cupples Rd San Antonio, TX 78237

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 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 4 residents (Resident #2) reviewed for accuracy of medical records.Resident #2 did not have foley catheter orders in Resident #2's November 2025 administration orders when he readmitted from the hospital with a foley catheter on 11/03/2025. This deficient practice could affect residents whose records were maintained by the facility and could place them at risk for errors in care and treatment. Findings included:Record review of Resident #2's undated face sheet revealed Resident #2 was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses that included retention of urine (inability to empty the bladder completely), schizophrenia (a chronic mental illness characterized by delusions, hallucinations, and disorganized thinking) and profound intellectual disabilities (a severe condition characterized by significant limitations in cognitive abilities and adaptive functioning).Record review of Resident #2's 5-day MDS assessment, dated 11/10/2025, revealed Resident #2 had short term and long-term memory deficits and severely impaired cognitive skills for decision making. Section H- Bladder and Bowel revealed Resident #2 had an indwelling foley catheter (a medical device that helps drain urine from the bladder) and was frequently incontinent with bowels. Record review of Resident #2's undated comprehensive care plan revealed Resident #2 had an indwelling catheter related to urinary retention, revision date 11/06/2025. An intervention revealed, change catheter per physician orders, date initiated 11/06/2025 and clean the catheter insertion site daily with mild soap and water. Ensure the drainage bag is changed per facility protocol, date initiated 11/06/2025. Record review of Resident #2's hospital discharge summary, admit date [DATE] and discharge date [DATE], revealed, 10/12 foley placed by urology and Flomax started. 10/15 voiding trial but foley later replaced on 10/18 and next Cath change should be done in about 2 weeks. Record review of a facility document titled admission Report, dated 11/03/2025, revealed Resident #2 had a foley catheter for urinary retention. Record review of Resident #2's November 2025 medication and treatment administration record revealed an order for enhanced barrier precautions related to an indwelling foley catheter every shift, start date 11/05/2025. The administration record did not reveal any orders for foley catheter care. Record review of Resident #2's physician order summary report revealed an order, foley catheter 16F (size of catheter) with 30cc balloon (component of the foley catheter). Change every month and PRN. Change drainage bag every 15th of the month and prn, dated 11/04/2025.Record review of Resident #2's nursing progress note, dated 11/04/2025, revealed Resident #2 admitted with a foley catheter intact. Record review of an EMR document titled, Task: B&B - Urinary Continence revealed Resident #2 was coded as, continence not rated due to indwelling catheter on 11/20/2025, 11/21/2025, 11/22/2025,11/23/2025, 11/24/2025 and 11/25/2025. During an observation of Resident #2, on 12/18/2025 at 4:05 p.m., Resident #2 was lying in a hospital bed with a foley catheter bag on the side of the bed. Resident #2 was being fed a meal by a staff member. Resident #2 was nonverbal and unable to respond to questions. During an interview with CNA A, on 12/19/2025 at 9:11 a.m., CNA A stated Resident #2 returned from the hospital at the beginning of November with a foley catheter. CNA A stated Resident #2 would drink fluids throughout the day and stated he would change his foley catheter bag, just about every hour during the shift. CNA A stated he would provide peri care to Resident #2 by cleaning the foley insertion area and tubing when providing peri care throughout the day. CNA A stated Resident #2's foley bag would become full very quickly due to the number of fluids that Resident #2 would consume throughout the day. CNA A stated he would notify the nurse if a resident's foley catheter bag were leaking and the nurse would replace the bag. CNA A stated he would document foley care in the EMR under a task for incontinent care. During an interview with LVN C, on 12/19/2025 at 9:51 a.m., LVN C stated Resident #2 was readmitted to the facility in November with a foley catheter. LVN C stated residents with foley catheters would have orders for cleaning the foley catheter site and emptying the bag each shift and replacing the foley bag and tubing monthly. LVN C stated the nurses were responsible for entering foley catheter orders into the physician orders and administration orders and stated any resident with a foley should have had orders for foley care. LVN C stated the nurses would document foley care on the administration record. LVN C stated Resident #2's foley bag was changed, about every 2 hours because his foley bag would fill up quickly. LVN C stated it was important for a resident to have foley orders so the nurses can document on the resident's care, to show that I did it During an interview with the DON, on 12/19/2025 at