STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455467	A. Building B. Wing	08/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Care Center of Alamo	8223 Broadway San Antonio, TX 78209

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to convey within 30 days the resident's funds upon discharge for 1 of 3 residents (Resident #9) reviewed for personal funds. The facility failed to ensure Resident #9's personal funds were conveyed within 30 days of the resident's self-initiated discharge from the facility. This failure could result in loss of personal funds or decreased quality life to residents. Findings included: Record review of Resident #9's face sheet, dated [DATE], revealed an [AGE] year-old male admitted to the facility on [DATE] and discharged home on [DATE]. Record review of Resident #9's discharge MDS, dated [DATE] revealed a BIMS score of 15, indicating no cognitive decline. Record review of Resident #9's HHSC Form 3618, dated [DATE] and printed on [DATE], revealed Resident #9's notification to the state of discharge home (return not anticipated) was processed and accepted by HHSC and the Texas Medicaid and Healthcare Partnership on [DATE]. Record review of Resident #9's transaction record of personal funds, dated [DATE], revealed Resident #9's account had a positive balance of $1,030.01 from a deposit on [DATE] with a description that read SSA Treas [number]. The Business Office Manager position at the facility was vacant at the time of survey, so no interview was performed. In an interview with the Admin. on [DATE] at 1:50 PM, she stated she was not the Admin. of the facility when the resident discharged . She stated that when a resident is discharged and the notification of discharge (form 3618) is processed, Medicaid and the SSA are notified that the account is closed so no further funds would deposit into a resident's account. She said the deposit in Resident #9's account was likely his monthly direct deposit from the SSA, and she explained that since Resident #9's form 3618 was processed after the deposit, he should have received a refund from the facility within 30 days. She was unsure why the refund had not been processed by the facility. She stated the facility's Business Office Manager had unexpectedly and suddenly died 3 days prior, and the facility was working with their corporate office to continue to operations of the Business Office. She stated she would ensure Resident #9 received a refund for the amount in the account. In an interview with Resident #9 on [DATE] at 2:10 PM, he stated he was not aware of the funds in the account at the facility. He stated he had not been notified by the facility that there was a deposit after he discharged home. He stated he spoke with the former Business Office Manager sometime in early August regarding home health care services, but she did not mention his personal funds account. She told him she would return his call regarding his issue, but he had not heard from her since then. Record review of the facility policy titled Resident Rights (dated 2025) revealed the following: The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands including: . required notices as specified in this section. The facility must furnish to each resident a written description of the legal which includes . a description of the manner in protecting personal funds.

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 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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedures for one resident (Resident #1) of 8 residents reviewed for abuse and neglect. The DON failed to notify the Administrator that Resident #1 intentionally cut herself on her right wrist with a shaving razor on 08/14/2025 in an attempt to inflict self-harm, and the Administrator failed to report the self-inflicted injury to the state agency. These failures had the potential to affect residents in the facility by placing them at risk for self-harm.The findings included: Record review of Resident #1's admission record (Face sheet) dated 08/19/2025 revealed she was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebral infarction (a condition where brain tissue dies due to a blockage in a blood vessel), anxiety disorder (excessive and persistent worry that interferes with daily life), hemiplegia affecting right dominant side (a condition where paralysis or weakness affects the right side of the body), and depression (a serious mood disorder that affects how one thinks, feels, and acts, often making daily activities difficult). Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 15/15 indicating the resident's cognitive skills for daily decision making were not impaired, she felt down/depressed/hopeless several days, and she sometimes felt socially isolated. The resident was able to ambulate with the use of a walker and eat, dress, toilet, and perform personal hygiene independently. Record review of Resident #1's comprehensive care plan, updated 08/06/2025 and reviewed on 08/19/2025, revealed a focus area indicating the resident was at risk for changes in mood related to migraines, depression, insomnia, seizures, anxiety and pain; an initial mood evaluation where she reported little interest or pleasure in doing things; feeling down, depressed or hopeless; impaired sleep pattern; little energy; feeling bad about self; and having a hard time concentrating on things (initiated 05/02/2025). The goal was for the resident to have improved mood state through the review date (initiated 05/02/2025, revised on 07/24/2025). Interventions/tasks included: Administering medications as ordered and monitoring for side effects and effectiveness; assisting the resident to identify strengths and positive coping skills; behavioral health consults as needed; monitoring/recording mood to determine if problems seem to be related to external causes; and monitoring/recording/reporting to MD prn risk for harming others; increased anger, labile mood or agitation; feeling threatened by others or thoughts of harming someone; possession of weapons or objects that could be used as weapons (all initiated 05/02/2025). The care plan also revealed focus areas for the resident's use of antidepressant medication, with the intervention/task of monitor/document/report PRN social isolation, suicidal thoughts and withdrawal (initiated 04/22/2025); and the resident's anxiety diagnosis and use of antianxiety medication, with the interventions/task of monitoring/documenting/reporting PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions, intentionally harming or trying to harm self, refusing to eat, drink, take medications or therapies or sense of hopelessness, impaired judgment or safety awareness (initiated 04/22/2025). There was no focus area in Resident #1's comprehensive care plan indicating the resident had a history of and hospitalization for a suicidal ideation on 05/14/2025 and had also attempted to injure herself on 08/14/2025. Record review of a progress note dated 05/14/2025 at 7:27 AM in Resident #1's EHR revealed the resident was found crying in her bedroom by a CNA. Resident #1 stated she did not want to live and did not want to be here anymore. The resident's RP and MD were contacted and the resident was transferred to the hospital. The resident returned to the facility on [DATE] to the general population. Record review of Resident #1's psychiatric evaluation dated 05/14/2025 during her hospital admission noted the resident was physically able to harm herself, was not supervised at her current facility, and would potentially be able to do so. The psychiatrist recommended a memory care facility with closer observation. Record review of a progress note by LVN B dated 08/14/2025 at 5:00 PM in Resident #1's EHR dated 08/14/2025 at 5:00 PM revealed the resident was bleeding from her right wrist with a women's shaving razor on the bed beside her. The resident informed the nurse she wanted to die and to go to the hospital. Pressure was applied to the site, the wound was cleaned, treated with antibiotic cream, and dressed with a

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observations, interviews and record reviews, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments to reflect the current condition for 2 of 14 residents (Resident #8 and # 1) reviewed for care plan revisions. 1. The facility failed to ensure Resident #1's care plan was comprehensive and reflected Resident #1's history of hospitalization for suicidal ideation on 05/14/2025 and had attempted to injure herself on 08/14/2025.2. The facility failed to ensure Resident #8's care plan was comprehensive and updated to reflect Resident #8 used a geriatric chair (a large, padded chair with wheeled bases, designed to assist seniors with limited mobility) as a fall prevention. This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs. Findings include: 1. Record review of Resident #1’s admission record (Face sheet) dated 08/19/2025 revealed she was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebral infarction (a condition where brain tissue dies due to a blockage in a blood vessel), anxiety disorder (excessive and persistent worry that interferes with daily life), hemiplegia affecting right dominant side (a condition where paralysis or weakness affects the right side of the body), and depression (a serious mood disorder that affects how one thinks, feels, and acts, often making daily activities difficult). Record review of Resident #1’s quarterly MDS dated [DATE] revealed a BIMS score of 15/15 indicating the resident’s cognitive skills for daily decision making were not impaired, she felt down/depressed/hopeless several days, and she sometimes felt socially isolated. Record review of Resident #1’s comprehensive care plan, reviewed 08/06/2025, revealed a focus area indicating the resident was at risk for changes in mood related to migraines, depression, insomnia, seizures, anxiety and pain; an initial mood evaluation where she reported little interest or pleasure in doing things; feeling down, depressed or hopeless; impaired sleep pattern; little energy; feeling bad about self; and having a hard time concentrating on things (initiated 05/02/2025). The goal was for the resident to have improved mood state through the review date (initiated 05/02/2025, revised on 07/24/2025). Interventions/tasks included: Administering medications as ordered and monitoring for side effects and effectiveness; assisting the resident to identify strengths and positive coping skills; behavioral health consults as needed; monitoring/recording mood to determine if problems seem to be related to external causes; and monitoring/recording/reporting to MD prn risk for harming others; increased anger, labile mood or agitation; feeling threatened by others or thoughts of harming someone; possession of weapons or objects that could be used as weapons (all initiated 05/02/2025). There was no focus area noting the resident had a history of and hospitalization for a suicidal ideation on 05/14/2025 and had also attempted to injure herself on 08/14/2025. Record review of a progress note dated 05/14/2025 at 7:27 AM in Resident #1’s EHR revealed the resident was found crying in her bedroom by a CNA. Resident #1 stated she did not want to live and “did not want to be here anymore.” The resident’s RP and MD were contacted and the resident was transferred to the hospital. The resident returned to the facility on [DATE]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1’s psychiatric evaluation dated 05/14/2025 during her hospital admission revealed the resident was physically able to harm herself, was not supervised at her current facility, and would potentially be able to do so. The psychiatrist recommended a memory care facility with closer observation. During an interview on 08/19/2025 at 2:30 PM, Resident #1 was agitated and stated she was upset and believed the staff was talking about her behind her back and posting about her on social media. During an interview on 08/22/2025 at 4:20 PM, the Administrator stated she had assumed the position of administrator earlier that month. She was out of town the day Resident #1 attempted to injure herself. She received a call from the DON, who described the situation as the resident having a suicidal ideation. During an interview on 08/22/2025 at 4:30 PM, the DON stated he called the Administrator on 08/14/2025 and told her Resident #1 was sent to the hospital. He recalled describing the resident cutting herself but did not recall if he used the term suicide attempt, as it was an ongoing situation. He remembered Resident #1 being hospitalized in May 2025 for a suicidal ideation but was unaware of the recommendation by the psychiatrist to have the resident admitted to a secure unit. The DON did not believe the resident needed a secure unit at that time and could be managed with increased supervision. The resident’s care plan should have been updated in May 2025 to note the resident’s history of suicidal ideation and in August 2025 to note the resident’s attempt to injure herself. 2. Record review of Resident #8’s admission Record (Face sheet) dated 8/23/25, revealed she was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Alzheimer’s diseases (progressive loss of memory and cognitive decline that impairs an individual to perform daily tasks), dementia (cognitive decline that impairs an individual to preform activities of daily living), high blood pressure, anxiety disorder (excessive and persistent worry that interferes with daily life). Record review of Resident #8’s MDS, a Significant Change assessment dated [DATE] revealed the resident’s cognitive skills for daily decision making were moderately impaired, used a wheelchair for mobility, was under hospice care, and since the previous assessment had 1 fall with no injury. Record review of Resident #8’s care plan for hospice services revealed it was initiated 07/29/2025 with a goal “…to focus on comfort, dignity, and quality of life during my remaining time.” Record review of Resident #8’s care plan for “Resident #8 is at risk for falls r/t [related to] impaired mobility, impaired cognition…history of falls, use of walker and wheelchair” revealed it was initiated 8/24/24 and revised on 08/06/2025 with the addition of interventions of “care plan scheduled with family and hospice” and “up at nurses’ station while anxious”. The care plan did not have a geriatric chair listed as an intervention to prevent falls. Record review of Resident #8’s Physician Orders revealed an order dated 07/25/2025 to admit to Hospice A services. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8’s Texas Medicaid Hospice Election form, dated 07/25/2025 revealed she was admitted to hospice care with terminal diagnoses of Senile Degeneration of the Brain (severe cognitive impairment that inhibits an individual’s ability to perform activities of daily living). Record review of Resident #8’s SBAR, dated 7/30/25 at 03:32 (3:32 AM), completed by the ADON revealed the resident had a fall because she tried to get up and walk without assistance, the resident’s vital signs were obtained, the responsible party was notified, and the physician was notified. Record review of Resident #8’s nurse’s note, dated 07/30/2025 at 05:23 (5:23 AM), LVN E noted “[Resident #8] at the nurses’ station still trying to get up medicated for anxiety and pain. ” Record review of Resident #8’s nurse’s note, dated 07/30/2025 at 07:19 (7:19 AM), LVN E noted “Fall with swelling to right eyes [sic] family member and hospice decided to send her out to hospital ER for eval [evaluation]”. Record review of Resident #8’s nurse’s note, dated 07/31/2025 at 11:34 (11:34 AM), ADON noted the resident was in bed resting, family was at bedside, it was status post fall day 1, and the resident had bruising to forehead, nose, and lips; and the hospice nurse was in the facility. In a telephone interview on 08/22/2025 from 3:13 PM to 3:55 PM, LVN E stated he worked the night shift (11 PM – 7 AM) on the memory care unit. LVN E stated Resident #8 had recently declined, she would try to get up and walk without assistance which caused her to fall. LVN E stated fall prevention measures included being near Resident #8 when she was in a wheelchair to remind the resident to “sit back” in the chair because otherwise she would try to walk and would fall. LVN E stated Resident #8’s hospice company provided a geriatric chair for the resident to use after she was sent to the hospital for a fall in July. LVN E said Resident #8 would try to get up from the geriatric chair when in the reclined position so staff would have to be near the resident when she was in it. LVN E stated Resident #8 had 2 falls in one night in July, he wasn’t certain on the date as he didn’t have her clinical record in front of him. LVN E stated one of the falls happened in the resident’s room, fall mats were on the floor when he entered the room, he didn’t see any injuries to the resident after that fall and took the resident to the nurse’s station while he notified Hospice A of the fall. Then later when Resident #8 was sitting at the nurses’ station, she fell again because she had tried to get up and had placed her body weight to the right side of the wheelchair and fell which caused a bump above her eye. LVN E stated he obtained her vital signs, did neurological checks, notified hospice and the resident’s responsible party. Observations on 08/22/2025 from 5:33 PM to 5:43 PM revealed Resident #8 was sitting at a dining table in a wheelchair with the DON sitting next to the resident. Resident #8 tried to stand up multiple times during the meal service, and the DON reminded her in Spanish to sit back down each time as he assisted her with the evening meal. Observation on 08/23/2025 at 5:34 AM revealed Resident #8 was sitting in the geriatric chair, which was reclined back, was awake, occasionally would say something in Spanish and was not trying to get out of the geriatric chair. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/23/2025 from 6:24 AM to 7:05 AM revealed Resident #8 was next to the nurses’ station sitting in the geriatric chair, which was reclined back, was awake, fiddling with the blanket that was on her lap, speaking Spanish at times, was not agitated and did not try to get out of the geriatric chair. Observation on 08/23/2025 from 9:24 AM to 9:45 AM revealed Resident #8 was sitting in the geriatric chair that was pushed up to the dining room table next to the nurses’ station and the chair was not reclined. The resident was dipping a spoon into a bowl of oatmeal that was on the table. She was not trying to get out of the chair and would speak in Spanish to other residents who walked by her, she was not agitated. In a telephone interview on 08/23/2025 at 11:53 AM, Hospice RN A stated Resident #8 was provided a geriatric chair from Hospice A on 07/29/2025, but she did not know the reason the chair was provided as she was the weekend on-call nurse and did not provide care to Resident #8. In an interview on 08/23/2025 at 3:41 PM, ADON stated Hospice A provided Resident #8 with the geriatric chair after she came back from the hospital after she had a fall. ADON stated she thought Resident #8’s family member wanted the resident to be up so hospice felt the geriatric chair was better for the resident so she wouldn’t fall. In an interview on 08/23/2025 at 4:09 PM, CNA F stated the geriatric chair was used as a measure to prevent Resident #8 from falling but the resident could get herself out of the geriatric chair when it was reclined and had done so the previous weekend when CNA F worked on the secured unit, so staff would be near Resident #8 when she was in the geriatric chair to ensure this did not happen. In an interview on 08/23/2025 from 3:27 PM to 3:38 PM, MDS Nurse stated Resident #8’s Risk for Falls care plan was updated on 08/06/2025 when the interventions of having the resident up at the nurses’ station when anxious and scheduled care plan with family and hospice were added. The MDS Nurse stated she did not know when Resident #8 was provided with the geriatric chair, the chair was used as in intervention for positioning to calm her down and because of her fall risk. The MDS Nurse verified the geriatric chair was not listed as an intervention and she didn’t not have a reason why it was not added to the care plan. Record review of the facility’s undated Care Plan Revisions Upon Status Change policy revealed “The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. …1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. Procedure for reviewing and revising the care plan when a resident experiences a status change: a. Upon identification of change in status, the nurse will notify the MDS Coordinator, the physician, and he resident representative, if applicable. b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options…d. The care plan will be updated with the new or modified interventions…f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member…”.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 remains as free of accident hazards as is possible; and to ensure resident receives adequate supervision to prevent accidents for 2 of 4 residents (Residents #1 and #2) reviewed for accidents and hazards. 1. The facility failed to ensure the environment was free of hazards to Resident #1 after the resident was hospitalized for suicidal ideation on 05/14/2025 and then on 08/14/2025 the resident attempted to self-infict an injury to her wrist with a razor. Resident #1 was discovered with a bleeding right wrist and a shaving razor on her bed on 08/14/2025 at 5:00 PM. 2. The facility failed to ensure Resident #1 was provide supervision the resident after being hospitalized for a suicidal ideation on 05/14/2025, resulting in the resident's attempt at self-injury on 08/14/2025.3. The facility failed to put effective measures in place to prevent Resident #2 from eloping from the memory care unit on 07/04/2025. An IJ was identified on 8/21/2025. The IJ template was provided to the facility on 8/21/2025 at 12:44 PM. While the IJ was removed on 8/23/2025 at 2:27 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm because the facility needed to evaluate the effectiveness of the POR and complete required staff training. These failures could place residents at risk of inadequate supervision and monitoring leading to an environment that is not free of accidents/hazards. Findings included: 1. Record review of Resident #1’s admission record (Face sheet) dated 08/19/2025 revealed she was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebral infarction (a condition where brain tissue dies due to a blockage in a blood vessel), anxiety disorder (excessive and persistent worry that interferes with daily life), hemiplegia affecting right dominant side (a condition where paralysis or weakness affects the right side of the body), and depression (a serious mood disorder that affects how one thinks, feels, and acts, often making daily activities difficult). Record review of Resident #1’s quarterly MDS dated [DATE] revealed a BIMS score of 15/15 indicating the resident’s cognitive skills for daily decision making were not impaired, she felt down/depressed/hopeless several days, and she sometimes felt socially isolated. The resident was able to ambulate with the use of a walker and eat, dress, toilet, and perform personal hygiene independently. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1’s comprehensive care plan, updated 08/06/2025 and reviewed on 08/19/2025, revealed a focus area indicating the resident was at risk for changes in mood related to migraines, depression, insomnia, seizures, anxiety and pain; an initial mood evaluation where she reported little interest or pleasure in doing things; feeling down, depressed or hopeless; impaired sleep pattern; little energy; feeling bad about self; and having a hard time concentrating on things (initiated 05/02/2025). The goal was for the resident to have improved mood state through the review date (initiated 05/02/2025, revised on 07/24/2025). Interventions/tasks included: Administering medications as ordered and monitoring for side effects and effectiveness; assisting the resident to identify strengths and positive coping skills; behavioral health consults as needed; monitoring/recording mood to determine if problems seem to be related to external causes; and monitoring/recording/reporting to MD prn risk for harming others; increased anger, labile mood or agitation; feeling threatened by others or thoughts of harming someone; possession of weapons or objects that could be used as weapons (all initiated 05/02/2025). The care plan also revealed focus areas for the resident's use of antidepressant medication, with the intervention/task of monitor/document/report PRN social isolation, suicidal thoughts and withdrawal (initiated 04/22/2025); and the resident's anxiety diagnosis and use of antianxiety medication, with the interventions/task of monitoring/documenting/reporting PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions, intentionally harming or trying to harm self, refusing to eat, drink, take medications or therapies or sense of hopelessness, impaired judgment or safety awareness (initiated 04/22/2025). There was no focus area in Resident #1's comprehensive care plan indicating the resident had a history of and hospitalization for a suicidal ideation on 05/14/2025 and had also attempted to injure herself on 08/14/2025. Record review of Resident #1's electronic Physician's Orders revealed orders for: -Duloxetine HCL oral capsule delayed release sprinkle 30 mg, give one capsule by mouth one time a day for depression with an order date of 08/06/2025 and a start date of 08/07/2025 -Duloxetine HCL oral capsule delayed release sprinkle 60 mg, give one capsule by mouth one time a day for depression with an order date of 04/22/2025 and a start date of 04/23/2025 -Hydroxyzine HCL oral tablet 25 mg, give one tablet by mouth every 8 hours as needed for anxiety with an order and start date of 08/05/2025 Record review of Resident #1's Medication Administration Record from 08/01/2025 - 08/20/2025 revealed she was monitored daily for side effects to antianxiety medication but only monitored on 08/20/2025 for side effects to antidepressant medications. Record review of a progress note dated 05/14/2025 at 7:27 AM in Resident #1’s EHR revealed the resident was found crying in her bedroom by a CNA. Resident #1 stated she did not want to live and “did not want to be here anymore.” The resident’s RP and MD were contacted and the resident was transferred to the hospital. The resident returned to the facility on [DATE] to the general population. Record review of Resident #1’s psychiatric evaluation dated 05/14/2025 during her hospital admission noted the resident was physically able to harm herself, was not supervised at her current facility, and would potentially be able to do so. The psychiatrist recommended a memory care facility with closer observation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Care Center of Alamo	8223 Broadway San Antonio, TX 78209

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's EHR revealed the resident received routine psychiatric care, with the most recent psychiatric assessment on 08/13/2025. The note revealed staff reported the resident seemed paranoid and delusional at times, thinking people were talking about her and she did not want to take medications from the staff. The provider spoke with the resident's sister, who confirmed the resident had a history of non-compliance with medications. The note revealed the resident was anxious but not suicidal and there was no risk of aggression. Record review of a progress note by LVN B dated 08/14/2025 at 5:00 PM in Resident #1's EHR dated 08/14/2025 at 5:00 PM revealed the resident was bleeding from her right wrist with a women's shaving razor on the bed beside her. The resident informed the nurse she wanted to die and to go to the hospital. Pressure was applied to the site, the wound was cleaned, treated with antibiotic cream, and dressed with a dry dressing. The wound was superficial and approximately 2 cm long. The resident's vital signs were taken and within normal ranges. The DON was informed, the resident's physician and RP were notified, the resident was on 1:1 watch until transport arrived, and the resident was transported to the ER. The resident returned to the facility on [DATE] to her previous room, which was not on the memory care unit. Record review of a self-reported incident filed by the administrator of the facility on 08/16/2025 revealed: “Brief narrative summary of the reportable incident: Resident sent out to hospital on [DATE] due to suicidal ideation. Returned to facility today 08/16/2025 with hospital records that resident with acute fracture to right ulnar and a healing fracture of distal radius.” During an interview on 08/19/2025 at 2:30 PM, LVN A stated Resident #1 was agitated the morning she cut her right wrist, but later relaxed and asked to speak with the ADON. She had contacted the resident’s psychiatric NP but she didn’t get back to her that day. She spoke to the resident’s family member. LVN A stated she was aware of Resident #1's suicidal ideation and hospitalization in May 2025 and informed management she believed it would be better for Resident #1 to be placed in memory care because it was safer, residents could not have glass or scissors, and staff would go through items brought by family members. During an interview on 08/19/2025 at 2:40 PM, CNA G stated she had never seen Resident #1 sad but the other CNA who cares for her reported she was occasionally depressed after coming back from an outing with her family. Her family brought her things, such as food and personal care items. She never saw the resident try to hurt herself. Residents were not allowed to have razors; if she saw one, she would report it to a nurse. Resident #1 got along well with her roommate. An observation on 08/19/2025 at 3:56 PM revealed the clean utility room was unlocked and contained ladies’ and men’s shaving razors, nail clippers and aerosol cans of deodorant. During an interview on 08/20/2025 at 8:04 AM, LVN C stated he was told in May 2025 that Resident #1 had thoughts of killing herself and did not want to live but had no plan. He contacted her physician and they sent her to the hospital for evaluation. He spoke with her family, and they reported she tended to have hallucinations. He did not know how she obtained a razor. He recalled the resident had groceries delivered that day, so it was possible it was in one of the bags. The clean utility room did not have a lock, but the staff supervised it. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/20/2025 at 10:05 AM, the ADON stated she had gone into Resident #1’s room sometime between 10:00 – 10:30 AM on 08/14/2025 and Resident #1 told her she was crying because she believed everyone was talking about her. At 5:00 PM, the ADON and DON received a call from LVN B that Resident #1 was having an emergency situation. They both went to Resident #1’s room and observed the resident laying on her bed and holding her right wrist with a towel. LVN B stated it looked like the resident attempted to use a razor to cut herself. The ADON remained with the resident while LVN B called psychiatric services, the resident’s doctor and the resident’s family. The resident was calm at this time. The resident was transferred to the hospital. During an interview on 08/22/2025 at 4:20 PM, the Administrator stated she had assumed the position of administrator earlier that month. She was out of town the day Resident #1 attempted to injure herself. She received a call from the DON, who described the situation as the resident having a suicidal ideation and she did not believe the resident's attempt to injure herself with the razor was a suicide attempt, and she did not believe the resident's attempt to injure herself with the razor was a suicide attempt and required reporting to the state agency. During an interview on 08/22/2025 at 4:30 PM, the DON stated he called the Administrator on 08/14/2025 and told her Resident #1 was sent to the hospital. He recalled describing the resident cutting herself but did not recall if he used the term suicide attempt, as it was an ongoing situation. He remembered Resident #1 being hospitalized in May 2025 for a suicidal ideation but was unaware of the recommendation by the hospital psychiatrist to have the resident admitted to a secure unit. The DON did not believe the resident needed a secure unit and could be managed with increased supervision. Record review of the facility policy Incidents and Accidents, revised 04/11/2025, revealed, Policy explanation: The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care. 5. The following incidents/accidents require an incident/accident report but are not limited to: self inflicted injuries; suicide or attempted suicide. Record review of the facility policy Resident Rights, updated 20252, revealed, Resident rights. The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 8. Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Record review of the facility’s policy, “Abuse, Neglect and Exploitation,” updated 2025, revealed, “It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. VII. Reporting/Response. A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.” (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Immediate Jeopardy was identified on 08/21/2025. The Administrator and DON were notified of the Immediate Jeopardy on 08/21/2025 at 12:44 PM and were given a copy of the Immediate Jeopardy template and a Plan of Removal (POR) was requested. The facility's POR for the Immediate Jeopardy was accepted on 08/22/2025 at 10:16 AM and reflected the following: The Medical Director was notified of the Immediate Jeopardy on 08/22/2025 at 12:34 PM. 1. Immediate Actions Taken for Those Residents Identified: Action: Resident #1 assessed, first aid administered, Primary Physician notified orders given to send to ER for evaluation and treatment. Person(s) Responsible: Charge Nurse Date: 8/14/2025 Action: Resident #1 has been receiving psychiatric services since 6/23/2025. Prior to the 8/14/2025 incident, the resident seen on 8/13/2025. Most recent visit 8/20/2025. Person(s) Responsible: The facility's contract psychology and psychiatry services. Date: 8/13/2025, 8/20/2025, on-going Action: Resident #1 placed in secure unit per resident’s request. Person(s) Responsible: Director of Nursing and Assistant Director of Nursing Date: 8/20/2025 Action: Resident #1s room cleared of all items that the resident could use to harm self. Person(s) Responsible: Director of Nursing and Assistant Director of Nursing Date: 8/14/2025 Completed on the same day Action: Resident #1 care plan updated to reflect risk for suicidal behavior and need for increased supervision. Person(s) Responsible: Director of Nursing and Assistant Director of Nursing Date: 8/21/2025 2. How the Facility Identified Other Possibly Affected Residents: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action: Conduct safe surveys with residents/family for signs of suicidal ideation. No other residents identified. If a resident expresses or exhibits signs/symptoms of suicidal ideation during a safe survey assessment: The staff member immediately notifies the Charge Nurse, DON/ADON, and Administrator. The physician and psychiatric provider are contacted immediately for further evaluation and treatment orders. The resident is placed on one-to-one monitoring until cleared by a licensed practitioner. The resident’s responsible party is notified. The care plan is updated with individualized interventions within 24 hours. Documentation is completed in PCC, including a behavior note and entry on the 24-hour report. If the DON/Administrator is unavailable, the ADON or RN Supervisor assumes responsibility to ensure no delay in intervention. Person(s) Responsible: Director of Nursing and Assistant Director of Nursing, Charge Nurse, Administrator Date: 8/22/2025 by 5 pm and ongoing Action: For Suicidal Ideation: Reviewed current resident population for diagnosis associated with suicidal Ideation and updated care plans with individualized interventions (e.g. Assess for underlying causes, consult mental health and/or psychiatric provider, individualized behavior intervention, Implement a behavior monitoring). Person(s) Responsible: Director of Nursing and Assistant Director of Nursing Date: 8/21/2025 Action: Suicidal Ideation: Conduct staff interviews to ask staff if any residents who: Have exhibited or voiced suicidal ideation: Has a plan, withdrawing from activities and family/friends, extreme mood swings, eating or sleeping pattern change, making statements like “I want to hurt myself” Person(s) Responsible: Director of Nursing and Assistant Director of Nursing Social Services Date: 8/21/2025 Action: Reviewed Incident Reports and Nursing Notes for the past 6 months to identify residents with suicidal ideation. No other residents identified. Person(s) Responsible: Director of Nursing and Assistant Director of Nursing, Social Services Date: 8/21/2025 Action: Upon admission and/or identification of suicidal ideation, the resident will be provided education regarding the importance of reporting suicidal thoughts to staff and the interventions available for support. The responsible party and family members will also receive education on recognizing signs of suicidal ideation and the importance of communicating concerns to facility staff. Education will be documented in the resident’s medical record and reflected in the individualized care plan. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Person(s) Responsible: Director of Nursing and Assistant Director of Nursing, Social Services, Date: Ongoing Action: All suicidal or self-harm behaviors will be documented in PointClickCare (PCC) through: Behavior Monitoring Flowsheets, 24-Hour Report, and/or Progress notes. Staff are trained to immediately escalate any report of suicidal ideation or self-harm. If the DON/Administrator is unavailable or on leave, the ADON or designated RN Supervisor assumes responsibility for receiving notifications and ensuring interventions are implemented without delay. All incidents will be reviewed by the interdisciplinary team and integrated into the residents’ individualized care plan within 24 hours. Person(s) Responsible: Director of Nursing and Assistant Director of Nursing, RN Supervisor, Charge Nurses Action: Elopement: Conduct staff interviews: ask staff if any residents who: Have exhibited signs of attempting to exit the facility (testing door alarms, approaching doors when other staff or visitors are entering/exiting). No other residents identified. Person(s) Responsible: DON/ADON Date: 8/22/2025 by noon Action: Suicidal Ideation: Education provided to all staff on suicidal ideation and measures to take if identified (notify DON/Administrator immediately). All staff will be educated prior to working their next shift and new staff will be educated prior to working their first shift. Person(s) Responsible: Director of Nursing and Assistant Director of Nursing Date: 8/22/2025 by 5 pm Action: Review all hospital documentation on residents that admitted or re-admitted over the past 3 months for documentation related to suicidal ideation. Continue to monitor all admissions/re-admissions documentation for suicidal ideation. Updated Care plans as needed. No new residents identified. Person(s) Responsible: Director of Nursing and Assistant Director of Nursing Administrator Date: 8/22/2025 by 5 pm and ongoing Action: Ensure current staff and new hires receive Incident, accident, and management of resident behavior training during orientation before working independently and annually thereafter. All staff will be educated prior to working their next shift and new staff will be educated prior to working their first shift. Person(s) Responsible: Director of Nursing and Assistant Director of Nursing (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Date: 8/22/2025 by 5 pm 3. Measures Put into Place/System Changes to remove the immediacy, and what date these actions occurred: Action: Suicidal Ideation: Education provided to all staff on suicidal ideation and measures to take if identified (notify DON/Administrator immediately). All staff will be educated prior to working their next shift and new staff will be educated prior to working their first shift. Person(s) Responsible: Director of Nursing and Assistant Director of Nursing Date: 8/22/2025 by 5 pm Action: Review all hospital documentation on residents that admitted or re-admitted over the past 3 months for documentation related to suicidal ideation. Continue to monitor all admissions/re-admissions documentation for suicidal ideation. Updated Care plans as needed. No new residents identified. Person(s) Responsible: Director of Nursing and Assistant Director of Nursing Administrator Date: 8/22/2025 by 5 pm and ongoing Action: Ensure current staff and new hires receive Incident, accident, and management of resident behavior training during orientation before working independently and annually thereafter. All staff will be educated prior to working their next shift and new staff will be educated prior to working their first shift. Person(s) Responsible: Director of Nursing and Assistant Director of Nursing Date: 8/22/2025 by 5 pm 4. How the Corrective Actions Will be Monitored/Ensure Comprehension, by whom and for how long: Action: The Interdisciplinary team will conduct daily room rounds Monday through Friday on all residents observing any items that could be used for self-harm (e.g. razors, sharp objects, cords, glass). The Manager on Duty will conduct rounds on Saturday and Sunday observing any items that could be used for self-harm (e. g. razors, sharp objects, cords, glass) and immediately remove those items. All rounds will be discussed in the morning meeting. Person(s) Responsible: Interdisciplinary Team and Manager on Duty Date: 8/22/2025 by 5 pm and ongoing (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action: Families will be educated on prohibited items during admission and re-educated as needed to ensure unsafe items are not brought into the facility. CNAs and nurses are trained to observe and report unsafe items daily while providing routine care. DON/ADON will review audit results weekly and document compliance in QAPI. Responsible: Director of Nursing and Assistant Director of Nursing, Charge Nurse Date: Ongoing Action: Interview 5 staff weekly x 4 weeks then monthly x 3 months to ensure no residents have voiced suicidal thoughts or attempted self-harm. With verbal comprehension of what to do in the event of resident self-harm or report of suicidal ideation. Responsible: Director of Nursing and Assistant Director of Nursing, Charge Nurse Action: Interview 5 staff weekly x 4 weeks then monthly x 3 months to ensure no residents have exhibited signs or attempts of elopement. With verbal comprehension of what to do in the event of elopement. Responsible: Director of Nursing and Assistant Director of Nursing, , Charge Nurse Date: Ongoing QAPI— Action: Medical Director informed of the deficient practice/IJ and the facility’s plan to remove the immediacy. Person(s) Responsible: Director of Nursing, Administrator, and/or Designee Date: 8/21/2025 The facility's verification of the POR was as follows: 1. Record review of progress note dated 08/14/2025 at 5:00 PM by LVN B revealed, “Pressure applied to site, cleansed with normal saline sol. patted dry, TAO, dry dressing applied, wound superficial 2cm long. T-98.8, P-105, R-20, BP-133/85. DON, NP notified. Record review of progress note dated 08/14/2025 at 8:46 PM by NP revealed, “Chief Complaint: Suicidal ideations, took shaving disposable razor and cut wrist sent to ER.” 2. Record review of Resident #1’s electronic health record revealed psychiatric notes dated 06/23/25, 06/25/25, 07/09/25, 07/30/25, 08/06/25, 08/13/25 and 08/20/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Record review of documentation from facility revealed interviewed 48 residents on signs of suicidal ideation. After the POR was accepted, record review of Resident #10's EHR revealed the resident stated to social worker on 08/22/20225 at 11:59 AM he wanted to hurt himself with a plan (he wanted to walk out into freeway; however, resident is bed-bound and not ambulatory). Resident #10 was evaluated by the psych NP the same day and sent to the hospital. Care plan was updated in a timely manner. 7. Staff interviews were conducted on 08/21 - 08/22/2025. RN/LVN = 11; CNA = 18; Dietary = 8; Housekeeping/Laundry/Maintenance = 5; PT/OT = 7; Admin = 8. Staff not interviewed will be interviewed prior to beginning work from 08/22 - 08/25/2025. Staff was asked: o Has any resident ever expressed to you that they may want to self-harm: o Do you know of any residents that you feel would potentially be at risk of self-harm? o If you suspect any resident of self-harm, what would you do? o Who would you report this to? All staff indicated no resident expressed to them a desire for self harm, they were unaware of any residents at potential risk for self-harm, and if they suspected such a risk they would report this immediately to the charge nurse/DON. 8. Record review revealed one resident was identified with a suicidal ideation on 08/08/2025. The resident was sent to the hospital immediately and returned to the facility on [DATE]. This resident verbalized another SI on 08/21/2025 and was again sent to the hospital. 9. Record review of Resident #1’s electronic health record revealed in psych note dated 08/20/2025 the resident received education regarding the importance of reporting suicidal thoughts to staff and the interventions available for support. The resident’s RP also received education on recognizing signs of suicidal ideation and the importance of communicating concerns to facility staff. 10. Record review of resident electronic health records revealed documentation in PointClickCare of resident suicidal and self-harm behaviors for Residents #1 and Resident #10. 11. Record review 8/22/2025 at 3:50 PM of staff roster provided by Admin on 8/22 indicating staff that received in-service training/were asked about elopement behaviors. RN/LVN = 11; CNA = 18; Dietary = 8; Housekeeping/Laundry/Maintenance = 5; PT/OT = 7; Admin = 8. Staff not interviewed will be interviewed prior to beginning work from 08/22 - 08/25/2025. 12. Record review revealed facility included in Resident Welcome Packet section on Restricted Items which included unsafe items. 13. Called the facility's medical director on 08/22/2025 at 12:35 PM; left voice message requesting return call. Record review of QAPI sign-in roster revealed Psych NP was present and the medical director participated by phone. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Record review of Resident #2's face sheet, dated 8/19/2025, revealed a [AGE] year-old female admitted to the facility on [DATE] and discharged home on 7/8/2025. Relevant diagnoses included senile degeneration of the brain (progressive memory and cognitive decline), schizophrenia (a mental health illness that causes difficulty distinguishing reality from their own thoughts and delusions), and dementia (a progressive disorder affecting cognition and behavior). Record review of Resident #2's physician orders revealed an order dated 7/3/2025 indicating the resident was admitted to the facility for a planned, five-day hospice-respite stay. Record review of Resident #2's discharge MDS, dated [DATE] revealed a BIMS score of 00, indicating severe cognitive decline. Record review of Resident #2's baseline care plan, date printed 8/19/2025, revealed the following: Resident demonstrates wandering and/or exit-seeking behavior placing self at risk for elopement or injury, had elopement on 7/4/2025. Record review of Resident #2's progress notes revealed the following documentation, dated 7/4/2025 at 1:12 PM by LVN D: Resident was seen 5 Minutes before this nurse went into nurses station restroom, after this nurse