STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455523	A. Building B. Wing	04/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morningside Manor	602 Babcock Rd San Antonio, TX 78201

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to have evidence that all alleged violations of abuse, neglect, exploitation, or mistreatment were thoroughly investigated to prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation was in progress for 1 of 2 residents (Resident #1) reviewed for neglect. The facility failed to ensure the previous Executive Director A followed the facility's Abuse Prevention Program policy, when she did not complete an investigation of neglect that involved Resident #1 and did not submit a 3613A Provider Investigation Report to HHSC. This failure could place residents at risk of not being provided with services to meet their needs or prevent them from being neglected.Findings include: Record review of Resident #1's admission Record, dated 04/11/2026, revealed the resident was an [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included diabetes (chronic condition characterized by high blood sugar levels cause by insulin resistance or lack of insulin production), anemia (low levels of red blood cells which transport oxygen in the blood causing pale skin and fatigue), vascular dementia (decline in thinking skills caused by conditions that block or reduce blood flow to the brain), cerebral infarction (stroke), and high blood pressure. Record review of Resident #1's Quarterly MDS Assessment, dated 03/05/2026, revealed the resident had short-term and long-term memory problems, and her cognitive skills for daily decision making were severely impaired. Record review of Resident #1's Care Plans revealed a care plan for Resident #1 experiencing alteration in mood/behavior patterns as evidenced by easily annoyed; .racist, false accusations, refuses psych services, refuses certain staff related to being racist. Resident #1 will refuse care from staff if she thinks you are not affiliated with her political views with an initiation date of 03/13/2024. Interventions included to allow Resident #1 to verbalize emotions and validate feelings. Record review of Resident #1's Physician History & Physical, dated 03/17/2026, revealed she was admitted to the hospital on [DATE] for a urinary tract infection and new diagnosis of congestive heart failure (a chronic condition where the heart cannot pump enough blood to meet the body's needs, causing blood to back up and fluid to accumulate in the lungs and body) and was transferred back to the facility on [DATE]. Record review of Incident Investigation Worksheet for Intake #1028885, received 08/07/2025, revealed Executive Director A reported the Marketing Liaison was informed by hospital staff Resident #1 stated that she was unsure about returning to the facility because the resident thought the nursing home staff may be neglecting her because they did not share the same political views. The Executive Director had notified appropriate parties, an in-service on abuse and neglect was initiated. Record review of TULIP on 04/11/2026 revealed that no 3613A Provider Investigation Report had been submitted to HHSC for Intake #1028885. In an interview on 04/11/2026 at 10:41 a.m., Resident #1 stated the staff were not listening to me. When asked for clarification, Resident #1 started talking about how the facility used to have more channels on the TV and now there were 2 channels that were no longer available. When asked again how the employees treated her, Resident #1 restated they don't listen to me and did not elaborate, or give an example, or name an individual. In an interview on 04/11/2026 at 10:58 a.m., Executive Director B stated he started working at the facility in November 2025 and all that he could find for the facility's (continued on next page)

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

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation for Incident #1028885 were a couple of emails to a HHSC Surveyor D and the Preliminary Findings form from the August 2025 annual recertification survey, which he provided to the surveyor. In an interview on 04/11/2026 at 11:27 a.m., the DON stated during the facility's annual recertification survey in August 2025, they received a call from their Marketing Liaison who reported a hospital case manager informed the Marketing Liaison that Resident #1 had reported she felt neglected, so the facility did a self-report. The hospital also filed a complaint against the facility that involved Resident #1 that was investigated by the survey team. The DON stated the previous Executive Director A had asked a surveyor from the survey team if an investigation report was needed for Incident #1028885, but she did not know what the surveyor's response was. The DON stated she could not find a completed 3613A Provider Investigation Report for Intake #1028885 and could only find email communication the previous Executive Director had with a surveyor. In a further interview on 04/11/2026 at 11:58 a.m., Executive Director B stated he was able to find the in-services and resident safe surveys that were done for Incident #1028885. In a telephone interview on 04/11/2026 at 1:07 p.m. the previous Executive Director A stated she had been the facility's Executive Director from October 2023 to September 2025. Executive Director A said she remembered being notified by the facility's liaison or the hospital case manager that Resident #1 had expressed that she was not sure if she wanted to come back to the facility because the resident felt staff were holding things against her because of the resident's political views. Executive Director A stated she reported it to HHSC since the hospital case manager was questioning if the facility was a safe place for the resident to return to, which Resident #1 did choose to return to. Executive Director A said she thought she had completed an investigation and a 3613A Provider Investigation Report that was submitted to HSHC via email. Executive Director A stated she did not remember what HHSC Surveyor D's response back to her was when she asked about the need to complete the investigation report for Incident #1028885. Executive Director A said Resident #1 had a history of making allegations in the past that were care planned. In a further interview on 04/11/2026 at 4:06 p.m., Executive Director B stated they found an encrypted email Executive Director A had sent HHSC on 08/08/2025 but they did not have the password to the encrypted file, so they were not able to provide a 3613A Provider Investigation Report for Incident #1028885. Record review of the HHSC LTCR 3701 Preliminary Findings form, dated 08/07/2025 signed by HHSC Surveyor D and Executive Director A, revealed Incident #1028885 was not investigated during the annual recertification survey that was conducted from 08/05/2025 to 08/07/2025, but Complaint #1028516 was investigated. Record review of an email dated 08/07/2025, sent at 4:06 p.m. from Executive Director A to HHSC Surveyor D, revealed the Executive Director wrote she was working on her investigation report [for Intake #1028885], and wanted to know if the surveyor wanted the items shared with her as the Executive Director gathered them or have them submitted in one complete report once everything was complied. There was no indication in the email what HHSC Surveyor D's response was. Record review of an email dated 08/08/2025, sent at 4:42 p.m. from Executive Director A to HHSC Surveyor D, revealed the Executive Director had a follow-up question regarding the self-report for Resident #1 related to neglect. When you exited, you mentioned that a 5-day investigation was not required as the submission was determined to be a complaint and was unsubstantiated by the survey team. However, today I received an email from the HHSC Complaint and Incident department requesting that I submit my investigation report. Would you still recommend that I proceed with submitting it under these circumstances? I did reach out to my program manager but have not yet heard back. There was no indication in the email what HHSC Surveyor D's response was. Record review of an email dated 08/08/2025, sent at 1:43 p.m. from HHSC Complaint and Incident division to Executive Director A, had the subject line Submission, Self-Report, Morningside Manor with an encrypted attachment and there were no comments in the email. Record review of the facility's Abuse Prevention Program policy, revised 09/02/2009, revealed Reporting: Anyone who has reasonable cause to believe that a resident is in a state of abuse, neglect or exploitation must report it immediately to the Department Director or Administrator. The (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Department Director must then report to Administrator; who will in turn report to the .state office upon learning of the allegation. The investigation is to be initiated. The Administrator must follow internal policies that pertain to abuse, neglect and exploitation. A written report of the investigation is to be sent to [HHSC] no later than the fifth calendar day after the oral report.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every three months for 1 of 4 (Resident #4) residents reviewed for MDS assessments. The facility failed to complete Resident #4's Quarterly MDS Assessment within three months of their most recent comprehensive assessment. This failure could lead to residents not receiving necessary, complete, or correct care due to lack of current information for their care plans. Findings included: Record review of Resident #4's admission Record, dated 04/11/2026, revealed the resident was an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included spinal stenosis (narrowing of the spinal canal compressing nerves causing pain, numbness and leg cramping), diabetes (chronic condition characterized by high blood sugar levels cause by insulin resistance or lack of insulin production), anemia (low levels of red blood cells which transport oxygen in the blood causing pale skin and fatigue) and high blood pressure. Review of Resident #4's Annual MDS assessment dated [DATE] revealed the resident had no cognitive impairment with a BIMS score of 14 out of 15. Review of Resident #4's electronic health record under the MDS tab revealed there was not a more recent MDS Assessment submitted since 12/04/2025; the next ARD for the first Quarterly MDS Assessment was due 03/06/2026 and the Quarterly Assessment was 22 days overdue. In a telephone interview on 04/11/2026 at 4:40 p.m., MDS Nurse LVN C stated he would complete the residents' MDS's according to the schedule generated by the Electronic Health Record. MDS Nuse LVN C stated Resident #4's Quarterly MDS should have been completed on 03/06/2026 and was something that he had missed, and the harm in not completing a Quarterly MDS in the required time could result in the resident's care plan not being accurate. In an interview on 04/11/2026 at 4:55 p.m., the DON stated MDS Nurse LVN C was responsible for completing residents' MDS and then she would review them for accuracy. The DON stated Resident #4's last MDS assessment was an Annual Assessment completed on 12/04/2025, the next MDS Assessment was due on 03/06/2026 and she was not sure what happened to cause the MDS to not be completed. The DON stated the harm of not having the Quarterly MDS completed on time could result in the resident's care plan not being updated if there was a change in the resident's level of care. In an interview on 04/11/2026 at 5:12 p.m., Executive Director B stated they audit residents' MDS weekly to ensure they were accurate and current. Executive Director B reviewed Resident #4's electronic health record, stated an Annual MDS Assessment was completed on 12/04/2025 and the next MDS Assessment should have been completed in March 2026, but no harm came to the resident. Record review of the policy MDS 3.0 Completion, dated 2025, revealed Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan.1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of reach resident's functional capacity, using the RAI specified by the state.e. Quarterly Assessment - completed using an ARD no >92 days from the most recent prior quarterly or comprehensive assessment (counting ARD to ARD).