

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455597	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2026
NAME OF PROVIDER OR SUPPLIER Memorial Medical Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 307 W Cypress St San Antonio, TX 78212	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown sources are reported immediately but not later than 2 hours (for an injury of unknown origin involving 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 2 of 6 Residents (Residents #4 and #5) reviewed for abuse. 1.The facility failed to report an allegation of resident-to-resident abuse of Resident #5, when Resident #4 slapped Resident #5 in the face on 2/12/2026. 2.The facility failed to report an allegation of suicidal ideation symptoms for Resident #5 on 1/9/2026. This deficient practice could place residents at risk of harm by not having their abuse and neglect incidents investigated. Findings included:1.Review of Resident #4's admission record, dated 3/06/2026, reflected a [AGE] year-old female admitted [DATE]. Her diagnoses included Alzheimer's Disease (brain disorder that slowly destroys memory and thinking skills), anxiety disorder (mental health condition characterized by excessive, uncontrollable worry about everyday issues), depression mood disorder characterized by persistent feelings of sadness, loss of interest, and range of emotional physical problems), and spastic hemiplegia affecting left nondominant side (condition characterized by muscle stiffness and weakness on one side of the body). Review of Resident #4's admission MDS, dated [DATE], reflected a BIMS score of 03, indicating severely impaired cognition. The MDS reflected Resident #4's functional abilities of self-care and mobility as totally dependent on staff and required the use of a manual wheelchair. Review of Resident #4's care plan, dated 2/11/2026 and revised 2/14/2026, reflected the resident had cognitive impairment as evidenced by impaired decision making, impaired orientation, impaired communication related to language barrier, Spanish speaking only, potential for adverse side effects related to antidepressant medications sertraline and mirtazapine. Review of Resident #4's progress note, dated 2/12/2026 documented by RN D, Went inside the residents' [Residents #4 and #5] room to check on them when [Resident #5] told me to be careful with her roommate [Resident #4] because she slapped her face. Separated the residents [Residents #4 and #5], assessed them, and informed physician, ADON and relatives of what happened. Vital signs are stable, no pain or any discomfort, no injuries sustained. During an observation and interview 3/06/2026 at 3:16 PM Resident #4 she was observed lying down on her bed and periodically moving to a sitting position. She was Spanish speaking, her bed was positioned low, she had a fall mattress near her bed. Resident #4 was dressed well, groomed appropriately, no odors, and wearing a sun hat. A wheelchair was near her bed, the call light was within reach. Resident would say it was cold, she would smile, and she was observed sitting up, stretching her arms and out and reaching around her bed with little force. She said she did not know the residents and she just arrived here. The resident was confused and had limited words. She did not engage with surveyor during the interview. Her thought process was limited. Record review of an incident report titled, # 619 Resident to Resident, dated 2/12/2026 documented by RN D, reflected the following:Incident Description:Nursing Description: Went inside the resident's room to check on them when Resident #5 told me to be careful (continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>with her roommate because she slapped her face. Resident Description: Resident #5 said that she's just trying to eat breakfast inside her room while her roommate (Resident #4) keeps on mumbling words she doesn't understand and then slapped her in the face. Immediate Action Taken: Separated both the residents (Residents #4 and #5), assessed both the residents and put Resident #1 in front of the nurse's station. Injuries Observed at Time of Incident: No injuries observed at time of incident. 2. Review of Resident #5's admission record, dated 3/05/2026, reflected a [AGE] year-old female admitted [DATE] and re-admitted on [DATE]. Her diagnoses included Alzheimer's Disease (brain disorder that slowly destroys memory and thinking skills), major depressive disorder (serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities), recurrent, moderate, suicidal ideations (tendency to experience suicidal thoughts or behaviors repeatedly over time), repeated falls, and cognitive communication deficit (impairment in mental processes). Review of Resident #5's quarterly MDS, dated [DATE], reflected a BIMS score of 05, indicating severely impaired cognition. The MDS reflected Resident #5 completed functional abilities of self-care with some help and completed mobility independently without assistance and the use of a manual wheelchair. Review of Resident #5's care plan, dated 6/11/2024, reflected Resident #5 had physical functioning deficit related to muscle weakness [initiated 7/19/2024]. Record review further reflected Resident #5 was care planned for physically abusive behavior of cursing, yelling and throwing items due to agitation with a goal that Resident #5 would be able to be redirected if physically/verbally aggressive through the next review date and interventions included change rooms, document behaviors in the clinical record, and obtain antianxiety medication [initiated 1/13/2026 and revision 1/19/2026]. Record review reflected Resident #5 had the potential for adverse side effects related to antidepressant medications [revision 1/31/2026]. Review of Resident #5's Psychiatry Follow Up, dated 2/24/2026, reflected the following.: Per behavioral notes review, no agitation or acute psychiatric symptoms documented over the past month. Chart review shows pt [Resident #5] involved in recent resident to resident incident with roommate on 2/12/26. It was reported that patient [Resident #5] was slapped in the face by her roommate. No injuries sustained. Vitals were stable. Both residents were separated. Patient [Resident #5] reported no pain or distress afterwards. Pt [Resident #5] does not mention incident on exam. When asked how things are going in the facility, states good. Pt [Resident #5] does not recall incident at this time. Reports feeling safe in facility. No acute mood disturbances or behavioral concerns reported. Facility continued to investigate. Review of Resident #5's LMHC-Psychology Progress visit, dated 2/11/2026, reflected the following.: LCSW met with resident [Resident #5] to address symptoms of mental health diagnoses, adjustment to current facility, and the need for increased social cognitive engagement. Resident [Resident #5] was receptive to communication today. She denied SI/HI/AVH. Review of Resident #5's physician note, dated 1/9/2026, documented by Psychiatric Mental Health Nurse Practitioner reflected the following, Pt [Resident #5] seen via telehealth. Pt [Resident #5] consents to evaluation. Pt [Resident #5] reports overall mood is good. Denies depression or anxiety today. Reports eating and sleeping well. Pt [Resident #5] currently on 1:1 after it was reported she voiced wanting to kill herself. Pt [Resident #5] denied saying this when evaluated by her nurse. No plan was present at time of evaluation by nurse. Pt [Resident #5] denies active or passive SI at this time of evaluation. When asked if she made SI statements earlier, states she voiced that earlier because, I (Resident #5) got upset but I (Resident #5) didn't mean too. Denies plan, intent, or access to means at this time. Protective factors reviewed. Safety plan discussed. Pt [Resident #5] has not displayed any suicidal gestures per staff. Pt [Resident #5] is not a threat at this current moment. Will d/c 1:1 at this time. Staff instructed to contact provider for return of SI thoughts. Orders given to increase Sertraline from 50mg to 100mg PO QD. Also seen to follow up on recent physical altercation within the facility with former roommate. Pt [Resident #5] unable to provide details of incident at this time. States that's just the problem, I don't know what happened when asked about reported incident. Pt and roommate were separated. Pt [Resident #5] was moved to a different room. Facility to continue to investigate incident. Pt (continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[Resident #5] with NO further aggressive behaviors following incident. Review of Resident #5's progress note, dated 1/9/2026, documented by RN D, reflected the following.: Behavior(s)- Describe behaviors noted throughout shift: This nurse informed by another nurse that while walking down the hallway, the resident [Resident #5] stated, I am going to kill myself, and then walked away. This nurse immediately located the resident [Resident #5] and assessed for safety. Upon assessment, the resident [Resident #5] denied even making the above statement and denied any suicidal ideation, intent, or plan. Resident [Resident #5] appeared to be in good spirits, calm, and cooperative at the time of assessment. No signs of emotional distress noted. Resident [Resident #5] stated she never said that and continued to deny the comment throughout the interaction. Antecedent: Resident [Resident #5] was walking down hallways Intervention: This nurse immediately located the resident [Resident #5] and assessed for safety. Upon assessment, the resident [Resident #5] denied even making the above statement and denied any suicidal ideation, intent, or plan. Resident [Resident #5] appeared to be in good spirits, calm, and cooperative at the time of assessment. No signs of emotional distress noted. Review of an incident report titled #593 Resident to Resident dated 1/8/2026 reflected the following: Nursing Description: Patient [Resident #5] verbally and physically aggressive towards roommate. The nurse observed patient [Resident #5] calling roommate derogatory names and punched roommate in the jaw because [Resident #5] wanted the curtain closed and the roommate wanted it open. Patient [Resident #5] was moved from room [room number] to [room number]. Resident Description: Resident unable to give description. Immediate Action Taken: [Resident #5] was moved to another room. Head to toe assessment was completed. DON and ADM aware. Police report completed. Doctor was made aware. Injuries Observed at Time of Incident: No injuries observed at time of incident. During an interview on 3/05/2026 at 6:20 PM, the Regional Nurse said she was aware of the resident-to-resident incident on 2/12/2026 involving Residents #4 and #5. She said Resident #5 accused Resident #4 of slapping her. She said Resident #4 was taken to the nurse's station for observation, the aggressor was Resident #4. She said Resident #5 requested to be moved and she was relocated to another room in a different unit. She said this incident was not reported to the State, but it was documented as a resident-to-resident incident. She said it was alleged, nobody witnessed, and after head-to-toe assessment was completed on both residents, staff could not tell if it was true. The Regional Nurse said there were no marks. She said the secondary incident on 1/9/2026 regarding Resident #5 and suicidal ideation behaviors was also discussed. She said Resident #5 was assessed by staff, she was placed on 1:1 supervision, the Psychiatric Mental Health Nurse Practitioner also evaluated Resident #5 following the incident, PCP evaluated the resident, LCSW followed up with Resident #5 and determined there were no concerns. She said the resident also said she was upset and said something she should not have said. She said this incident would not be reported to the State. She said the ADM usually reported to the State and the DON in-service on specific topics addressing incidents. She said she was provided with details of the incident, and she made a recommendation to report or not report. She said ultimately it was the ADM's decision to accept her recommendation or not and to follow through with the report if it was reported. She said for this incident it was her recommendation not to report because she could not tell if it happened or not and there were no concerns with the residents. The Regional Nurse said the facility policy was to report any ANE within the hour. During a telephone interview on 3/05/2026 at 6:53 PM, the MDS Coordinator said ANE allegations were reported immediately to the Abuse Coordinator, the ADM. She said the IDT reviewed the physical and verbal incidents of 1/9/2026 and 2/12/2026 and the suicidal ideation incident on 1/9/2026 but and said she did not believe they required reporting. During an interview on 3/06/2026 at 10:45 AM, ADON B revealed she was knowledgeable on ANE, Resident Rights, and de-escalation techniques and provided examples. She said depending on the situation, resident to resident incidents, employee to resident incidents would need to be reported to the State. She said if an ANE allegation was reported to her she would report it to her ADM immediately and the ADM would be required to report it to the State within 2 hours. She (continued on next page)</p>		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>said failure in this process could be bad for residents and could result in harm to them. During an interview on 3/5/2026 at 1:53 PM, CNA H revealed she was knowledgeable on ANE, Resident Rights, and de-escalation techniques and provided examples. CNA H said if residents made suicidal statements she was to report it immediately to the charge nurse. During an interview on 3/06/2026 at 12:41 PM, MA A revealed she was knowledgeable on ANE, Resident Rights, and de-escalation techniques and provided examples. During an interview on 3/06/2026 at 5:31 PM, the Senior Director said she was aware of the incidents involving Resident #4 and Resident #5 and although their care plans were not updated with specific interventions the facility provided the residents with interventions that were captured in the incident reports, progress notes, and psych notes. The Senior Director said all potential allegations of ANE would be reported to the Abuse Coordinator, ADM. She said she reviewed the provider letter and encouraged the ADM and management team to follow the letter carefully, following reporting timeframes of 2 hours. She said the ADM needed to complete the provider investigation report within 5 days. She said if a resident reported to the nursing staff that another resident was physically aggressive towards them or wanted to hurt themselves this would warrant an abuse report. During an interview on 3/06/2026 at 6:36 PM, the Former ADM said she provided ANE training to her nursing staff and in-services covered resident to resident-initiated abuse and neglect, identifying signs of aggression, resident rights, and reporting incidents of ANE. She said staff were to report any allegations or suspicions to the abuse coordinator, her when she was in the position, now it would be to the interim ADM. She said she would review reporting incidents based on the provider letter and within 2 hours if ANE and 24 hours other self-report items. She said the impact of staff not reporting allegations or suspicions of ANE she would not be aware of and unable to report to the State. She said this failure could put the residents at risk of being abused. She said allegations of aggressive behavior would be reported. The Former ADM said aggressive behaviors and suicidal statements would be reported to the charge nurse, the MD would be notified and discussed with the IDT immediately. The Former ADM said she was aware of Resident #5's resident-to-resident abuse report on 1/9/2026 as she submitted it to the state and followed through with an investigation. She said she was not made aware of the incident of Resident #5 regarding SI on 1/9/2026 or the incident of Resident #4 and Resident #5 resident-to-resident abuse on 2/12/2026. She said had she been made aware of the incidents she would have reported them to the State and completed a provider investigation report. Record review of facility document titled, Abuse, Neglect and Exploitation, dated 7/25/2025, reflected the following: Policy: 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. Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment. Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Policy Explanation and Compliance Guidelines: I. The facility will develop and implement written policies and procedures that: b. Establish policies and procedures to investigate any such allegations. 2. The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. III. Prevention of Abuse, Neglect and Exploitation The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of (continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>residents with needs and behaviors which might lead to conflict or neglect, V. Identification of Abuse, Neglect and Exploitation A. The facility will have written procedures to assist staff in identifying the different types of abuse, mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations. V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. 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. B. The Administrator will follow up with government agencies during business hours, to confirm the initial report was received and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 2 of 6 residents (Residents #4 and #5) reviewed for assessments. 1.The facility failed to accurately reflect physical and verbal behavioral symptoms directed toward others on Resident #4's admission MDS, dated [DATE]. 2.The facility failed to accurately reflect physical and verbal behavioral symptoms directed toward others on Resident #5's significant change MDS, dated [DATE].3.The facility failed to accurately reflect Section D - Mood on Resident #5's quarterly MDS, dated [DATE], following her suicidal ideation symptoms on 1/9/2026 that implemented psych medications. These failures could place residents at risk for inadequate care due to inaccurate assessments. Findings included:1. Review of Resident #4's admission record, dated 3/06/2026, reflected a [AGE] year-old female admitted [DATE]. Her diagnoses included Alzheimer's Disease (brain disorder that slowly destroys memory and thinking skills), anxiety disorder (mental health condition characterized by excessive, uncontrollable worry about everyday issues), depression mood disorder characterized by persistent feelings of sadness, loss of interest, and range of emotional physical problems), and spastic hemiplegia affecting left nondominant side (condition characterized by muscle stiffness and weakness on one side of the body). Review of Resident #4's admission MDS, dated [DATE], reflected a BIMS score of 03, indicating severely impaired cognition. The MDS reflected the resident's functional abilities of self-care and mobility as totally dependent on staff and required the use of a manual wheelchair. The MDS reflected Resident #4 did not exhibit physical or behavior symptoms directed toward others. Resident #4's active diagnoses under neurological category included Alzheimer's Disease, Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke and Hemiplegia (complete or near-complete paralysis on one side) or Hemiparesis (partial weakness on one side of the body) and under the psychiatric/mood disorder category included Anxiety Disorder and Depression (other than bipolar) and she was taking antidepressants. Further review of Resident #4's admission MDS reflected care area was triggered, and care planning revisions occurred on 2/23/2026 for t cognitive loss/dementia, communication, falls, and psychotropic drug use. Further review of the admission MDS reflected no review or revision addressing Resident #1's psychosocial well-being, physical and verbal behavioral symptoms directed towards others and her refusal of medications and care. Review of Resident #4's care plan, dated 2/11/2026 and revised 2/14/2026, reflected Resident #4 had cognitive impairment as evidenced by impaired decision making, impaired orientation, impaired communication related to language barrier, Spanish speaking only, potential for adverse side effects related to antidepressant medications sertraline and mirtazapine. Further review of care plan revealed no review of revision following the MDS assessment on 2/20/2026, which triggered Care Areas including Cognitive Loss/Dementia, Communication, and Psychotropic Drug Use. During an observation and interview 3/06/2026 at 3:16 PM Resident #4 she was observed lying down on her bed and periodically moving to a sitting position. She was Spanish speaking, her bed was positioned low, she had a fall mattress near her bed. Resident #4 was dressed well, groomed appropriately, no odors, and wearing a sun hat. A wheelchair was near her bed, the call light was within reach. Resident would say it was cold, she would smile, and she was observed sitting up, stretching her arms and out and reaching around her bed with little force. She said she did not know the residents and she just arrived here. The resident was confused and had limited words. She did not engage with surveyor during the interview. Her thought process was limited. Review of Resident #4's progress note, dated 2/25/2026 documented by RN E, Resident [Resident #4] became physically aggressive during ADL care while CNA was assisting with personal care, resident [Resident #4] struck CNA with open hand, but CNA was able to avoid being struck. Care was paused immediately by CNA and resident [Resident #4] was redirected using calm verbal cues and reassurance. CNA allowed resident [Resident #4] space to de-escalate. After redirection, resident (continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[Resident #4] became less agitated and care was provided. Behaviors monitored and interventions implemented as needed. Review of Resident #4's progress note dated, 2/20/2026 documented by, RN D, Resident [Resident #4] noted to be verbally and physically aggressive toward staff during attempts to provide ADL care. When staff approached to assist with hygiene and dressing, resident [Resident #4] became verbally insulting, yelling and making derogatory statements. Upon continued attempts to provide care, resident [Resident #4] attempted to hit, push, and grab at staff. Staff maintained safety, stepped back, and avoided further escalation. Staff continued with calm approach, reassurance, and redirection. Family notified of [Resident #4's] behaviors and ongoing refusal of care. The family member arrived in facility and assisted with calming resident [Resident #4]. With family presence and reassurance, resident [Resident #4] allowed staff to complete ADL care without further aggression. Resident [Resident #4] continues to require frequent redirection due to cognitive impairment. Review of Resident #4's progress note, dated 2/17/2026 documented by, RN E, [Resident #4] Refused x 3 [three times] attempts. Resident [Resident #4] confused per usual self. Resident [Resident #4] combative with staff. Review of Resident #4's progress note, dated 2/13/2026 documented by, RN F, [Resident #4] refused all medications. Review of Resident #4's progress note, dated, 2/12/2026 documented by, RN D, Went inside the resident's [Residents #4 and #5] room to check on them when [Resident #5] told me to be careful with her roommate [Resident #4] because she slapped her face. Separated the residents [Residents #4 and #5], assessed them, and informed physician, ADON and relatives of what happened. Vital signs are stable, no pain or any discomfort, no injuries sustained. Record review of an incident report titled, #619 Resident to Resident, dated 2/12/2026 documented by RN D, reflected the following:Nursing Description: Went inside the resident's room to check on them when Resident #5 told me to be careful with her roommate (Resident #4) because she slapped her face.Resident Description: Resident #5 said that she's (Resident #5) just trying to eat breakfast inside her room while her roommate (Resident #4) keeps on mumbling words she doesn't understand and then slapped her in the face.Immediate Action Taken: Separated both the residents, assed both the residents and put Resident #4 in front of the nurse's station.Injuries Observed at Time of Incident: No injuries observed at time of incident. Review of Resident #4's progress note, dated, 2/11/2026 documented by, RN D, Resident [Resident #4] refused to have her weight checked. Resident [Resident #4] is being aggressive with staff. Review of Resident #4's progress note, dated, 2/11/2026 documented by, the Nurse Practitioner, Patient [Resident #4] is a poor historian due to cognitive and psychiatric impairment. Nursing reports baseline agitation and confusion. Baseline agitation and cognitive impairment complicate history-taking and care coordinator. 2. Review of Resident #5's admission record, dated 3/05/2026, reflected a [AGE] year-old female admitted [DATE] and re-admitted on [DATE]. Her diagnoses included Alzheimer's Disease (brain disorder that slowly destroys memory and thinking skills), major depressive disorder (serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities), recurrent, moderate, suicidal ideations (tendency to experience suicidal thoughts or behaviors repeatedly over time), repeated falls, and cognitive communication deficit (impairment in mental processes). Review of Resident #5's quarterly MDS, dated [DATE], reflected a BIMS score of 05, indicating severely impaired cognition. The MDS reflected Resident #5 completed functional abilities of self-care with some help and completed mobility independently without assistance and the use of a manual wheelchair. Resident #5 did not exhibit physical, or behavior symptoms directed toward others. Resident #5's active diagnoses under Heart/Circulation category included: Coronary Artery Disease (CAD); under Neurological category included: Alzheimer's Disease; and under Additional active diagnoses category included: other abnormalities of gait and mobility, muscle weakness, cognitive communication deficit, repeated falls and she was taking antidepressants. Further review of the quarterly MDS reflected no review or revision addressing Resident #5's psychosocial well-being, physical and verbal behavioral symptoms directed towards others and her refusal of medications and care. Review of Resident #5's care plan, dated 6/11/2024, (continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>reflected the resident had physical functioning deficit related to muscle weakness [initiated 7/19/2024]. Record review further reflected Resident #5 was care planned for physically abusive behavior of cursing, yelling and throwing items due to agitation with a goal that Resident #5 would be able to be redirected if physically/verbally aggressive through the next review date and interventions included change rooms, document behaviors in the clinical record, and obtain antianxiety medication [initiated 1/13/2026 and revision 1/19/2026]. Record review reflected Resident #5 had the potential for adverse side effects related to antidepressant medications [revision 1/31/2026]. Resident #5 has impaired communication related to cognitive communication deficit [revision 7/19/2024]; Resident #5 has potential for complications related to dementia [revision 5/18/2025]; Resident #5 refused care as evidence by choosing to leave items unbagged at bedside with interventions to include identify root cause of refusal and always use clear communication before attempting to attend to the person's self-care [revision 7/31/2024]. Further review of the care plan reflected no review or revision addressing Resident #5's psychosocial well-being following the suicidal ideation incident on 1/9/2026. Review of Resident #5's Psychiatry Follow Up, dated 2/24/2026, reflected the following, Per behavioral notes review, no agitation or acute psychiatric symptoms documented over the past month. Chart review shows pt [Resident #5] involved in recent resident to resident incident with roommate on 2/12/26. It was reported that patient [Resident #5] was slapped in the face by her roommate. No injuries sustained. Vitals were stable. Both residents were separated. Patient [Resident #5] reported no pain or distress afterwards. Pt [Resident #5] does not mention incident on exam. When asked how things are going in the facility, states good. Pt [Resident #5] does not recall incident at this time. Reports feeling safe in facility. No acute mood disturbances or behavioral concerns reported. Facility continued to investigate. Review of Resident #5's LMHC-Psychology Progress visit, dated 2/11/2026, reflected the following, LCSW met with resident [Resident #5] to address symptoms of mental health diagnoses, adjustment to current facility, and the need for increased social cognitive engagement. Resident [Resident #5] was receptive to communication today. She denied SI/HI/AVH. Review of Resident #5's physician note, dated 1/9/2026, documented by Psychiatric Mental Health Nurse Practitioner reflected the following, Pt [Resident #5] seen via telehealth. Pt [Resident #5] consents to evaluation. Pt [Resident #5] reports overall mood is good. Denies depression or anxiety today. Reports eating and sleeping well. Pt [Resident #5] currently on 1:1 after it was reported she voiced wanting to kill herself. Pt [Resident #5] denied saying this when evaluated by her nurse. No plan was present at time of evaluation by nurse. Pt [Resident #5] denies active or passive SI at this time of evaluation. When asked if she made SI statements earlier, states she voiced that earlier because, I (Resident #5) got upset but I (Resident #5) didn't mean too. Denies plan, intent, or access to means at this time. Protective factors reviewed. Safety plan discussed. Pt [Resident #5] has not displayed any suicidal gestures per staff. Pt [Resident #5] is not a threat at this current moment. Will d/c 1:1 at this time. Staff instructed to contact provider for return of SI thoughts. Orders given to increase Sertraline from 50mg to 100mg PO QD. Also seen to follow up on recent physical altercation within the facility with former roommate. Pt [Resident #5] unable to provide details of incident at this time. States that's just the problem, I don't know what happened when asked about reported incident. Pt and roommate were separated. Pt [Resident #5] was moved to a different room. Facility to continue to investigate the incident. Pt [Resident #5] with no further aggressive behaviors following incident. Review of Resident #5's progress note, dated 1/9/2026, documented by RN D, reflected the following, Behavior(s)- Describe behaviors noted throughout shift: This nurse informed by another nurse that while walking down the hallway, the resident [Resident #5] stated, I am going to kill myself, and then walked away. This nurse immediately located the resident [Resident #5] and assessed for safety. Upon assessment, the resident [Resident #5] denied even making the above statement and denied any suicidal ideation, intent, or plan. Resident [Resident #5] appeared to be in good spirits, calm, and cooperative at the time of assessment. No signs of emotional distress noted. Resident [Resident #5] stated she never said that and continued to deny (continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>the comment throughout the interaction. Antecedent: Resident [Resident #5] was walking down hallways Intervention: This nurse immediately located the resident [Resident #5] and assessed for safety. Upon assessment, the resident [Resident #5] denied even making the above statement and denied any suicidal ideation, intent, or plan. Resident [Resident #5] appeared to be in good spirits, calm, and cooperative at the time of assessment. No signs of emotional distress noted. Review of an incident report titled #593 Resident to Resident dated 1/8/2026 reflected the following: Incident Description: Nursing Description: Patient [Resident #5] verbally and physically aggressive towards roommate. The nurse observed patient [Resident #5] calling roommate derogatory names and punched roommate in the jaw because [Resident #5] wanted the curtain closed and the roommate wanted it open. Patient [Resident #5] was moved from room [room number] to [room number]. Resident Description: Resident unable to give description. Immediate Action Taken: [Resident #5] was moved to another room. Head to toe assessment was completed. DON and ADM aware. Police report completed. Doctor was made aware. Injuries Observed at Time of Incident: No injuries observed at time of incident. During an interview on 3/05/2026 at 11:48 AM, CNA G said Resident #5 was independent, required minimal supervision, she was sometimes in her moods, tried to escape, did not know where she was, and becomes verbally and physically aggressive towards staff. She said she was not aware of any incidents involving Resident #5 as she worked in another unit for the last 2-3 months. During an interview on 3/05/2026 at 6:20 PM, the Regional Nurse said that due to the recent loss of employees and transition of new employees including the ADM, DON, and ADON, she was assigned to the facility on a temporary basis. She said she understood the MDS assessment, but she did not update them. She said the MDS was required to be initiated and updated with interventions when needed. She said by not updating MDS assessments it could reduce the care that was required for a resident. She said she was aware of the resident-to-resident incident on 2/12/2026 involving Residents #4 and #5. She said Resident #5 accused Resident #4 of slapping her. She said Resident #4 was taken to the nurse's station for observation, the aggressor was Resident #4. She said there were no marks. She said the secondary incident on 1/9/2026 regarding Resident #5 and suicidal ideation behaviors was also discussed. She said Resident #5 was assessed by staff, placed on 1:1 supervision, the Psychiatric Mental Health Nurse Practitioner also evaluated Resident #5 following the incident, the PCP evaluated the resident, the LCSW followed up with Resident #5 and determined there were no concerns. She said the resident also said she was upset and said something she should not have said. During a telephone interview on 3/05/2026 at 6:53 p.m., the MDS Coordinator said she assisted on a part-time basis with MDS assessments and was part of IDT. She said she initiated and revised MDS assessments. She said the assessments helped the facility and staff understand what care needs were provided for a specific resident. She said she was aware of Residents #4 and #5's incident on 2/12/2026 of resident-to-resident abuse. She said the IDT meeting did occur, and interventions were noted in the meeting, but she was not clear as to why the MDS assessments were not updated. She said Resident #5's 1/9/2026 incident of physical and verbal symptoms and incident of suicidal ideation symptoms were reviewed by the IDT and interventions were implemented but were not updated in her MDS assessment. She said the facility's Social Worker would have more details about MDS assessments but was out of town and could not be reached. The MDS Coordinator said she recalled an IDT meeting discussing Resident #5's behaviors, but she did not understand why it was not documented and believed the team made an error and failed to document during the IDT. She said interventions were in place for the resident and she could not speak on the failure to update the MDS assessment with behaviors, but that it would be worked on. During an interview on 3/06/2026 at 10:45 AM, ADON B said she recalled the incident regarding Resident #5 on 1/9/2026, resident-to-resident physical altercation and suicide ideation. She said Resident #5 required partial assistance depending on what mood she was in, she had the tendency to think she is going home, she cursed staff and was verbally aggressive. She said when Resident #5 was on a rampage she did not care if someone was an employee or resident. ADON B said typically Resident #5 (continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>would become verbally aggressive three times out of the month, she did have interventions in place. She said she did have an incident where she was monitored a while back. She said the staff knows when she was having a rough day or if in a good mood it will be a good day. She said Resident #5 would be verbally aggressive and start saying things she did not mean and did not recall shortly after. She said Resident #5 received psych services and medications to help her with her mood. She said these behaviors were addressed during the IDT, but she was not sure why they were not updated in her MDS Assessment. During an interview on 3/5/2026 at 1:53 PM, CNA H said Resident #4 could be verbally aggressive, the first day she arrived at the facility she started swinging to hit the staff when they provided her with care. CNA H said Resident #4 was confused and not sure where she was. She said now the resident was on medications was calmer. She said she was familiar with the resident's care and interventions in place to help her de-escalate. CNA H said she recalled Resident #4's resident-to-resident incident with Resident #5 vaguely. CNA H said Resident #5 was not assigned to her unit. She said Resident #4 slapped Resident #5, but there were no marks. CNA H said she was familiar with the residents who can become verbally and physically aggressive and she had been provided with de-escalation techniques that help situations. She said Resident #5 was on North 1 unit, she provided visual care and supervision at times, she said Resident #5 did have behavior concerns and got mad when offering to wash her hair. During an interview on 3/06/2026 at 12:41 PM, MA A revealed she was knowledgeable on ANE, Resident Rights, and de-escalation techniques and provided examples. She said when Resident #4 arrived at the facility she was verbally and physically aggressive. She said interventions included her children visiting daily and this helped her to calm down her behaviors. She said Resident #4 has also been provided with medications that have assisted with behaviors and with time she had gotten used to the facility. During an interview on 3/06/2026 at 3:00 PM, Physical Therapy said Resident #4 could be verbally aggressive towards staff, especially during the afternoon, sundown. She said in the morning Resident #4 was in a good mood, but in the afternoon, she seemed more agitated, so she would have conversation with her in the mornings. During an interview on 3/06/2026 at 3:19 PM, CNA I said Resident #4 was normally physically aggressive and verbally aggressive towards her when she provided care. She said you would have to be within reach for her to physically hit you. During an interview on 3/06/2026 at 3:35 PM, CNA J said the staff should not need to endure abuse from residents. She said there were a few residents who could be verbally and physically abusive to other residents and staff and all incidents should be reported. She said if she were to witness ANE she would report it immediately to her charge nurse and up to the ADM. In a joint interview on 3/06/2026 at 4:25 PM, ADON K and the DON said the regional team consisting of the MDS Coordinator and MDS Coordinator L were helping with MDS assessments and care plans as there were a lot of staff transitioning out of the facility. She said IDT meetings were held by department heads, ADON, DOR, SW, ADM. During an interview on 3/06/2026 at 5:31 PM, the Senior Director said that if the residents have behaviors staff will work to identify what works for them. She said if a resident has physical or verbal aggression behaviors the team would get together to see what approaches will help the resident and incorporate interventions. She said if behaviors were not outlined in specific MDS assessments she would not be able to provide surveyor with information at this at this time as the LMSW who normally handles the MDS assessments was on vacation and out of the country. She said at this time there were regional resource staff that were at the facility helping to ensure MDS assessments were updated accurately and timely. The Senior Director said that multiple things, not just one thing, several factors showing a decline or change could warrant an MDS change. She said that she does not believe verbal and physical aggression along with psych service and medication management would trigger a significant MDS change but would be included in the next quarterly MDS. She said IDT meetings she recalled taking place following the 1/9/2026 and 2/12/2026 incidents were not documented in the resident's electronic medical record but that it would be updated. During an interview on 3/06/2026 at 6:36 PM, the Former ADM said if there is a cognitive change in status, any change in ADLs, regress of care, change of (continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>behavior, psych interventions and medications would be considered a significant change. She said she was unsure why Resident #4 and Resident #5's MDS assessments had not been updated to reflect their current behaviors and intervention. She said it was important to have accurate MDS assessments as it was important to provide complete care for residents. Record review of facility document titled, MDS 3.0 Completion dated October 2025 reflected the following: Policy: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. D. significant Change in Status Assessment (SCSA) - a comprehensive assessment completed within 14 days of identification of a status change that meets the requires outlined in Chapter 2 of the Versions 3.0 RAI Manual. i. A significant change is a major decline or improvement in a resident's status that: (1) will not normally resolve itself without interventions by staff or by implementing stand disease-related clinical interventions.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that include measurable objectives and time frames to meet residents' medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment and to ensure that the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including the right to refuse treatment for 3 of 6 residents (Residents #3, #4, and #5) reviewed for care plans. 1.The facility failed to update Resident #3's care plan to reflect Resident #3 had a behavior of refusing showers.2.The facility failed to update Resident #4's care plan to reflect refusal of medication and care, verbal and physical aggressive behaviors, and psych service interventions put in place following an incident on 2/12/2026.3.The facility failed to update Resident #5's care plan to reflect suicidal ideation symptoms following an incident on 1/9/2026. This failure could place residents at risk of not having their needs met and not receiving appropriate care. Findings included:1.Record review of Resident #3's admission record, dated 03/06/2026, reflected a [AGE] year-old male admitted on [DATE] with diagnoses to include Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory and thinking skills), cognitive communication deficit, need for assistance with personal care, impulse disorder, and major depressive disorder.</p> <p>Record review of Resident #3's quarterly MDS assessment, dated 01/09/2026, reflected Resident #3 had a BIMS score of 9 out of 15, indicating moderate cognitive impairment.</p> <p>Record review of Resident #3's care plan, undated, reflected no mention of Resident #3 refusing showers.</p> <p>Record review of Resident #3's bathing task in the last 30 days, undated, reflected Resident #3 had two baths completed in the last 30 days on 02/21/2026 and 03/03/2026. Resident #3's bathing task reflected Resident #3 refused eight baths in the last 30 days on 02/07/2026, 02/10/2026, 02/14/2026, 02/17/2026, 02/19/2026, 02/26/2026, 02/28/2026, and 03/05/2026.</p> <p>Record review of the facility's grievances reflected Resident #3 had complaints of not being changed and not being showered., dated 02/21/2026.</p> <p>Interview and observation on 03/06/26 at 01:27 PM, Resident #3 revealed that he was not receiving showers and denied that he refused showers. He appeared well-kempt (description for someone that is neat, tidy, well-groomed, or well-maintained) with no foul odor.</p> <p>Interview on 03/06/2026 at 03:23PM, LVN C revealed Resident #3 refused showers sometimes even when the staff offered at different times in the day and after some encouragement too. He revealed Resident #3's refusal of showers should be documented in the care plan so that it did not look like they were not offering Resident #3 showers.</p> <p>Interview on 03/06/26 at 04:36PM, the DON revealed shower refusals should be documented because it's the resident's right to refuse. She further revealed that it can help our staff know to encourage Resident #3 to shower. She revealed it was important so we can respect his rights, but the facility still tried to make sure Resident #3 was clean and hygienic.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Review of Resident #4's admission record, dated 3/06/2026, reflected a [AGE] year-old female admitted [DATE]. Her diagnoses included Alzheimer's Disease (brain disorder that slowly destroys memory and thinking skills), anxiety disorder (mental health condition characterized by excessive, uncontrollable worry about everyday issues), depression mood disorder characterized by persistent feelings of sadness, loss of interest, and range of emotional physical problems), and spastic hemiplegia affecting left nondominant side (condition characterized by muscle stiffness and weakness on one side of the body).</p> <p>Review of Resident #4's admission MDS, dated [DATE], reflected a BIMS score of 03, indicating severely impaired cognition. The MDS reflected Resident #4's functional abilities of self-care and mobility as totally dependent on staff and required the use of a manual wheelchair. The MDS reflected Resident #4 did not exhibit physical or behavior symptoms directed toward others. Resident #4's active diagnoses under neurological category included Alzheimer's Disease, Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke and Hemiplegia (complete or near-complete paralysis on one side) or Hemiparesis (partial weakness on one side of the body) and under the psychiatric/mood disorder category included Anxiety Disorder and Depression (other than bipolar) and she was taking antidepressants. Further review of Resident #4's admission MDS reflected care area was triggered, and care planning revisions occurred on 2/23/2026 for t cognitive loss/dementia, communication, falls, and psychotropic drug use. Further review reflected no review or revision addressing Resident #4's psychosocial well-being, physical and verbal behavioral symptoms directed towards others and her refusal of medications and care.</p> <p>Review of Resident #4's care plan, dated 2/11/2026 and revised 2/14/2026, reflected Resident #4 had cognitive impairment as evidenced by impaired decision making, impaired orientation, impaired communication related to language barrier, Spanish speaking only, potential for adverse side effects related to antidepressant medications sertraline and mirtazapine. Further review of care plan revealed no review of revision following the MDS assessment on 2/20/2026, which triggered Care Areas including Cognitive Loss/Dementia, Communication, and Psychotropic Drug Use.</p> <p>During an observation and interview 3/06/2026 at 3:16 PM Resident #4 she was observed lying down on her bed and periodically moving to a sitting position. She was Spanish speaking, her bed was positioned low, she had a fall mattress near her bed. Resident #4 was dressed well, groomed appropriately, no odors, and wearing a sun hat. A wheelchair was near her bed, the call light was within reach. Resident would say it was cold, she would smile, and she was observed sitting up, stretching her arms and out and reaching around her bed with little force. She said she did not know the residents and she just arrived here. The resident was confused and had limited words. She did not engage with surveyor during the interview. Her thought process was limited.</p> <p>Review of Resident #4's progress note dated, 2/25/2026 documented by RN E Resident [Resident #4] became physically aggressive during ADL care while CNA was assisting with personal care, resident [Resident #4] struck CNA with open hand, but CNA was able to avoid being struck. Care was paused immediately by CNA and resident [Resident #4] was redirected using calm verbal cues and reassurance. CNA allowed resident [Resident #4] space to de-escalate. After redirection, resident [Resident #4] became less agitated and care was provided. Behaviors monitored and interventions implemented as needed.</p> <p>Review of Resident #4's progress note dated, 2/20/2026 documented by, RN D Resident [Resident #4] noted to be verbally and physically aggressive toward staff during attempts to provide ADL care. When staff approached to assist with hygiene and dressing, resident [Resident #4] became verbally (continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>insulting, yelling and making derogatory statements. Upon continued attempts to provide care, resident [Resident #4] attempted to hit, push, and grab at staff. Staff maintained safety, stepped back, and avoided further escalation. Staff continued with calm approach, reassurance, and redirection. Family notified of [Resident #4's] behaviors and ongoing refusal of care. Family member arrived in facility and assisted with calming resident [Resident #4]. With family presence and reassurance, resident [Resident #4] allowed staff to complete ADL care without further aggression. Resident [Resident #4] continues to require frequent redirection due to cognitive impairment.</p> <p>Review of Resident #4's progress note dated 2/17/2026 documented by, RN E [Resident #4] Refused x 3 attempts. Resident [Resident #4] confused per usual self. Resident [Resident #4] combative with staff.</p> <p>Review of Resident #4's progress note dated 2/13/2026 documented by, RN F [Resident #4] refused all medications.</p> <p>Review of Resident #4's progress note dated, 2/12/2026 documented by, RN D Went inside the resident's [Residents #4 and #5] room to check on them when [Resident #5] told me to be careful with her roommate [Resident #5] because she slapped her face. Separated the residents [Residents #4 and #5], assessed them, and informed physician, ADON and relatives of what happened. Vital signs are stable, no pain or any discomfort, no injuries sustained.</p> <p>Review of an incident report titled, #619 Resident to Resident dated 2/12/2026 documented by RN D reflected the following:</p> <p>Incident Description:</p> <p>Nursing Description: Went inside the resident's room to check on them when Resident # told me to be careful with her roommate because she slapped her face.</p> <p>Resident Description: Resident said that she's just trying to eat breakfast inside her room while her roommate keeps on mumbling words she doesn't understand and then slapper her in the face.</p> <p>Immediate Action Taken: Separated both the residents, assed both the residents and put Resident #4 in front of the nurse's station.</p> <p>Injuries Observed at Time of Incident: No Injuries observed at time of incident.</p> <p>Review of Resident #4's progress note dated, 2/11/2026 documented by, RN D Resident [Resident #4] refused to have her weight checked. Resident [Resident #4] is being aggressive with staff.</p> <p>Review of Resident #4's progress note dated, 2/11/2026 documented by, Nurse Practitioner Patient [Resident #4] is a poor historian due to cognitive and psychiatric impairment. Nursing reports baseline agitation and confusion. Baseline agitation and cognitive impairment complicate history-taking and care coordinator.</p> <p>Record review of facility's policy Comprehensive Care Plans, dated 05/05/2025, reflected 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. (continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Review of Resident #5's admission record, dated 3/05/2026, reflected a [AGE] year-old female admitted [DATE] and re-admitted on [DATE]. Her diagnoses included Alzheimer's Disease (brain disorder that slowly destroys memory and thinking skills), major depressive disorder (serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities), recurrent, moderate, suicidal ideations (tendency to experience suicidal thoughts or behaviors repeatedly over time), repeated falls, and cognitive communication deficit (impairment in mental processes).</p> <p>Review of Resident #5's quarterly MDS, dated [DATE], reflected a BIMS score of 05, indicating severely impaired cognition. The MDS reflected Resident #5 completed functional abilities of self-care with some help and completed mobility independently without assistance and the use of a manual wheelchair. Resident #5 did not exhibit physical, or behavior symptoms directed toward others. Resident #5's active diagnoses under Heart/Circulation category included: Coronary Artery Disease (CAD); under Neurological category included: Alzheimer's Disease; and under Additional active diagnoses category included: other abnormalities of gait and mobility, muscle weakness, cognitive communication deficit, repeated falls and she was taking antidepressants. Further review of the quarterly MDS reflected no review or revision addressing Resident #5's psychosocial well-being, physical and verbal behavioral symptoms directed towards others and her refusal of medications and care.</p> <p>Review of Resident #5's care plan, dated 6/11/2024, reflected Resident #5 had physical functioning deficit related to muscle weakness [initiated 7/19/2024]. Record review further reflected Resident #5 was care planned for physically abusive behavior of cursing, yelling and throwing items due to agitation with a goal that Resident #5 would be able to be redirected if physically/verbally aggressive through the next review date and interventions included change rooms, document behaviors in the clinical record, and obtain antianxiety medication [initiated 1/13/2026 and revision 1/19/2026]. Record review reflected Resident #5 had the potential for adverse side effects related to antidepressant medications [revision 1/31/2026]. Resident #5 has impaired communication related to cognitive communication deficit [revision 7/19/2024]; Resident #5 has potential for complications related to dementia [revision 5/18/2025]; Resident #5 refused care as evidence by choosing to leave items unbagged at bedside with interventions to include identify root cause of refusal and always use clear communication before attempting to attend to the person's self-care [revision 7/31/2024]. Further review of the care plan reflected no review or revision addressing Resident #5's psychosocial well-being following the suicidal ideation incident on 1/9/2026.</p> <p>Review of Resident #5's LMHC-Psychology Progress visit, dated 2/11/2026, reflected the following: LCSW met with resident [Resident #5] to address symptoms of mental health diagnoses, adjustment to current facility, and the need for increased social cognitive engagement. Resident [Resident #5] was receptive to communication today. She denied SI/HI/AVH.</p> <p>Review of Resident #5's physician note dated 1/9/2026 documented by Psychiatric Mental Health Nurse Practitioner reflected the following: Pt [Resident #5] seen via telehealth. Pt [Resident #5] consents to evaluation. Pt [Resident #5] reports overall mood is good. Denies depression or anxiety today. Reports eating and sleeping well. Pt [Resident #5] currently on 1:1 after it was reported she voiced wanting to kill herself. Pt [Resident #5] denied saying this when evaluated by her nurse. No plan was present at time of evaluation by nurse. Pt [Resident #5] denies active or passive SI at this time of evaluation. When asked if she made SI statements earlier, states she voiced that earlier because I got upset but I didn't mean too. Denies plan, intent, or access to means at this time. Protective factors reviewed. Safety plan discussed. Pt [Resident #5] has not displayed any suicidal (continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>gestures per staff. Pt [Resident #5] is not a threat at this current moment. Will d/c 1:1 at this time. Staff instructed to contact provider for return of SI thoughts. Orders given to increase Sertraline from 50mg to 100mg PO QD. Also seen to follow up on recent physical altercation within the facility with former roommate. Pt [Resident #5] unable to provide details of incident at this time. States that's just the problem, I don't know what happened when asked about reported incident. Pt and roommate were separated. Pt [Resident #5] was moved to a different room. Facility to continue to investigate incident. Pt [Resident #5] with NO further aggressive behaviors following incident.</p> <p>Review of Resident #5's progress note dated 1/9/2026, documented by RN D reflected the following: Behavior(s)- Describe behaviors noted throughout shift: This nurse informed by another nurse that while walking down the hallway, the resident [Resident #5] stated, I am going to kill myself, and then walked away. This nurse immediately located the resident [Resident #5] and assessed for safety. Upon assessment, the resident [Resident #5] denied even making the above statement and denied any suicidal ideation, intent, or plan. Resident [Resident #5] appeared to be in good spirits, calm, and cooperative at the time of assessment. No signs of emotional distress noted. Resident [Resident #5] stated she never said that and continued to deny the comment throughout the interaction.</p> <p>Antecedent: Resident [Resident #5] was walking down hallways</p> <p>Intervention: This nurse immediately located the resident [Resident #5] and assessed for safety. Upon assessment, the resident [Resident #5] denied even making the above statement and denied any suicidal ideation, intent, or plan. Resident [Resident #5] appeared to be in good spirits, calm, and cooperative at the time of assessment. No signs of emotional distress noted.</p> <p>Review of an incident report titled, #593 Resident to Resident dated 1/8/2026 reflected the following:</p> <p>Incident Description:</p> <p>Nursing Description: Patient [Resident #5] verbally and physically aggressive towards roommate. The nurse observed patient [Resident #5] calling roommate derogatory names and punched roommate in the jaw because [Resident #5] wanted the curtain closed and the roommate wanted it open. Patient [Resident #5] was moved from room [room number] to [room number].</p> <p>Resident Description: Resident unable to give description.</p> <p>Immediate Action Taken: [Resident #5] was moved to another room. Head to toe assessment was completed. DON and ADM aware. Police report completed. Doctor was made aware.</p> <p>Injuries Observed at Time of Incident: No Injuries observed at time of incident.</p> <p>During an interview on 3/05/2026 at 6:20 PM, the Regional Nurse said due to the recent loss of employees and transition of new employees including the ADM, DON, and ADON, she was assigned to the facility on a temporary basis. She said she understood the MDS assessment, but she did not update them. She said the MDS was required to be initiated and updated with interventions when needed. She said by not updating MDS assessments it could reduce the care that was required for a resident. She said she was aware of the resident-to-resident incident on 2/12/2026 involving Residents #4 and #5. She said Resident #5 accused Resident #4 of slapping her. She said Resident #4 was taken to the nurse's station for observation, the aggressor was Resident #4. She said there were no marks. She said the secondary incident on 1/9/2026 regarding Resident #5 and suicidal ideation (continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>behaviors was also discussed. She said Resident #5 was assessed by staff, placed on 1:1 supervision, the Psychiatric Mental Health Nurse Practitioner also evaluated Resident #5 following the incident, the PCP evaluated the resident, the LCSW followed up with Resident #5 and determined there were no concerns. She said the resident also said she was upset and said something she should not have said. She said she could not recall why the documented behaviors for Residents #4 and #5 were not updated on their care plan, but this would be taken care of today.</p> <p>During a telephone interview on 3/05/2026 at 6:53 p.m., the MDS Coordinator said she assisted on a part-time basis with MDS assessments and was part of IDT. She said she initiated and revised MDS assessments. She said the assessments helped the facility and staff understand what care needs were provided for a specific resident. She said she was aware of Residents #4 and Resident #5's incident on 2/12/2026 of resident-to-resident abuse. She said the IDT meeting did occur, and interventions were noted in the meeting, but she was not clear as to why the MDS assessments were not updated. She said Resident #5's 1/9/2026 incident of physical and verbal symptoms and incident of suicidal ideation symptoms were reviewed by the IDT and interventions were implemented but were not updated in her MDS assessment. She said the facility's Social Worker would have more details about MDS assessments but was out of town and could not be reached. The MDS Coordinator said she recalled an IDT meeting discussing Resident #5's behaviors, but she did not understand why it was not documented and believed the team made an error and failed to document during the IDT. She said interventions were in place for the resident and she could not speak on the failure to update the MDS assessment with behaviors, but that it would be worked on. She said she could not recall why the documented behaviors for Resident #4 and Resident #5 were not updated on their care plan, but this would be taken care of today.</p> <p>During an interview on 3/06/2026 at 10:45 AM, ADON B said care plans provided the nursing staff with specific care for residents. She said care plans should be updated frequently and with important information for each resident. She said the nursing staff could not provide quality care without this information, and it could be harmful to residents. ADON B said staff were good at conducting shift changes and relaying pertinent information to the oncoming staff. She said she recalled the incident regarding Resident #5 on 1/9/2026, resident-to-resident physical altercation and suicide ideation. She said Resident #5 required partial assistance depending on what mood she was in, she thought she was going home, she cursed staff and was verbally aggressive. She said when Resident #5 was on a rampage she did not care if someone was an employee or resident. ADON B said typically Resident #5 would become verbally aggressive three times out of the month, she did have interventions in place. She said she did have an incident where she was monitored a while back. She said the staff knows when Resident #5 was having a rough day or if in a good mood it will be a good day. She said Resident #5 would be verbally aggressive and start saying things she did not mean and did not recall shortly after. She said Resident #5 did receive psych services and medications to help her with her mood. She said these behaviors had been addressed during the IDT, but she was not sure why they had not been updated in the resident's care plan.</p> <p>During interview on 3/5/2026 at 1:53 PM, CNA H said Resident #4 could be verbally aggressive, the first day she arrived she started swinging to hit the staff when they provided her with care. CNA H said Resident #4 was confused and not sure where she was. She said now the resident was on medications she was calmer. She said she was familiar with her care and interventions in place to help her de-escalate. At times residents' behaviors would be listed in their plan of care and it would be important to be aware of how to help them. She said at times she will not review the care plan, but the team does an excellent job with shift change and relaying all the information needed to care for a resident including Resident #4. CNA H said she recalled Resident #4's resident-to-resident incident (continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>with Resident #5 vaguely. CNA H said Resident #5 was not assigned to her unit. She said Resident #4 slapped Resident #5, but there were no marks. She said Resident #5 was on North 1 unit, she did provide visual care and supervision at times, she said she did have behavior concerns and got mad when offering to wash her hair. CNA H said if she had residents making suicidal statements she was to report it immediately to the charge nurse.</p> <p>During an interview on 3/06/2026 at 12:41 PM, MA A said when Resident #4 arrived at the facility she was verbally and physically aggressive. She said interventions included her children visiting daily and this helped her to calm down her behaviors. She said Resident #4 had also been provided with medications that have assisted with behaviors and with time she had gotten used to the facility.</p> <p>During an interview on 3/06/2026 at 3:00 PM, Physical Therapy said Resident #4 could be verbally aggressive towards staff, especially during the afternoon, sundown. She said in the morning Resident #1 was in a good mood, but in the afternoon, she seemed more agitated. She said she was assisting her with transfer training, wheelchair mobility, neuro with weight shift and reaching. She said Resident #4 has a fear of standing or falling and cannot stand up on her own. She said someone would have to be within reach for her to hit them and said she did not have the ability to reach out and intentionally hit someone. She said she worked with Resident #5 previously and she tends to shut down if physical therapy becomes challenging. She said she has not witnessed Resident #5 become verbally or physically aggressive. Physical Therapy said the nursing staff work with the residents appropriately. She said they helped the residents de-escalate if they were having a rough day.</p> <p>During an interview on 3/06/2026 at 3:19 PM, CNA I said care plans are necessary for staff to know what care a resident requires. She said the team helped each other and during shift change she was provided with all the details and anything new to care for a resident. She said Resident #4 was normally physically aggressive and verbally aggressive towards her when she provided care. She said you would have to be within reach for her to physically hit you. She said the in-services on de-escalation techniques are helpful. She said if she was patient she could help de-escalate.</p> <p>During an interview on 3/06/2026 at 3:35 PM, CNA J said care plans help the staff provide the best possible care to the residents. She said without care plans being updated the staff could miss something and not provide necessary care for a resident. She said when she is providing care to a challenging resident who is abusive, she opts to provide care with a second staff member present. She said the staff should not need to endure abuse from residents.</p> <p>During a joint interview on 3/06/2026 at 4:25 PM, ADON K and DON said care plans are the responsibility of the MDS Coordinator and acute concerns are currently handled by Regional Nurse. She said the regional team consisting of the MDS Coordinator and MDS Coordinator L are helping with MDS assessments and care plans as there have been a lot of staff transitioning out of the facility. She said IDT meetings are held by department heads, ADON, DOR, SW, and ADM. DON said care plans are important to ensure continuity of care for residents. She said care plans are for nurses and aids, and should include total care, likes, dislikes, needs, 2-person assistance, behaviors, multiple wandering episodes. DON said there have been a high turnover of DONs recently, nobody solid. ADON K said she has been tasked with DON responsibilities with this high turnover. She said care plans generate general concerns and are used by the nursing staff to provide resident care. She said this is how the nursing staff and aids communicate with one another. She said the nursing staff and aids will review the care plan for interventions and she will review if the interventions are appropriate for residents. ADON K said she will ensure psych consultation and other interventions are added to care plans. She said all staff have access to the care plans.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/06/2026 at 5:31 PM, the Senior Director said that if the residents have behaviors staff will work to identify what works for them. She said if a resident has physical or verbal aggression behaviors the team would get together to see what approaches will help the resident and incorporate interventions. The Senior Director said she would not be able to provide surveyor with information on specific care plans at this time as LMSW, who normally handles the care plans, was on vacation and out of the country. She said at this time there were regional resource staff that were at the facility helping to ensure care plans were updated accurately and timely. The Senior Director said that multiple things, not just one thing, several factors showing a decline or change could warrant a significant change. She said that she does not believe verbal and physical aggression along with psych service and medication management would trigger a significant change but would review Resident #1 and Resident #5's care plans and update with specific interventions today.</p> <p>During an interview on 3/06/2026 at 6:36 PM, the Former ADM said if there is a cognitive change in status, any change in ADLs, regress of care, change of behavior, psych interventions and medications would be considered a significant change. She said she was unsure why Residents #4 and #5's care plans had not been updated to reflect their current behaviors and intervention. She said it was important to have accurate care plans as it was important to provide complete care for residents.</p> <p>Record review of facility document titled, MDS 3.0 Completion, dated October 2025, reflected the following: Policy: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan.</p> <p>Record review of facility document titled, Abuse, Neglect and Exploitation, dated 7/25/2025, reflected the following: Policy:</p> <p>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. III. Prevention of Abuse, Neglect and Exploitation The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain medical records on each resident that were complete, accurately documented, readily accessible, and were systematically organized, for 2 of 6 residents (Residents #1 and #2) reviewed for medical records. 1.The facility failed to ensure MA A documented she administered medication Methocarbamol Oral Tablet 750 MG to Resident #1 on 03/03/2026 at 9:00 PM.2.The facility failed to ensure LVN C document Y instead of N on Resident #2's January 2026 Medication Administration Record on 01/14/2026 during the day and 01/15/2026 during the day. These failures could place residents at risk for inaccurate medical records. The findings included: 1.Record review of Resident #1's admission record, dated 03/06/2026, reflected a [AGE] year-old female initially admitted [DATE] and re-admitted [DATE] with diagnoses to include Muscle weakness and low back pain. Record review of Resident #1's quarterly MDS assessment, dated 03/02/2026, reflected Resident #1 had a BIMS of 15 out of 15 reflected intact cognition. Record review of Resident #1's care plan, undated, reflected Potential for complications r/t Medication with intervention Medications as ordered., initiated 01/31/2026. Record review of Resident #1's Medication Admin Audit Report from 03/01/2025 to 03/05/2025, dated 03/06/2026, reflected Resident #1 had a doctor's order of Methocarbamol Oral Tablet 750 MG. Give 1 tablet by mouth three times a day for muscle spasms. It further reflected Methocarbamol Oral Table 750 MG was scheduled to be administered to Resident #1 on 03/03/2026 at 9 PM but the Medication Admin Audit Report reflected Methocarbamol was administered on 03/04/2026 at 06:03 AM. Interview on 03/04/36 at 03:29PM, Resident #1 revealed she received her medications on time. Interview on 03/06/26 at 12:41PM, MA A revealed she was supposed to administer medications one hour before and one hour after a medication was scheduled to be administered. She revealed she had forgotten to document right after she administered medication because she needed to help the other staff with resident care before she clocked out from work, but she always made sure that residents were administered their medication on time to follow the doctor's orders correctly. 2.Record review of Resident #2's admission record, dated 03/04/2026, reflected a [AGE] year-old male admitted on [DATE] with diagnoses to include anxiety disorder (excessive and persistent fears or worries that interfere with daily life) and cognitive communication deficit. Record review of Resident #2's quarterly MDS assessment, dated 12/02/2025, reflected Resident #2 could not have a BIMS conducted and had both short and long-term memory problems. It further revealed his cognitive skills for daily decision making were severely impaired. Record review of Resident #2's care plan, undated, reflected, [Resident #2] takes Antianxiety medication and is at risk for adverse effects for: Anxiety with intervention Observe him/her closely for significant side effects and report to MD Sedation, Drowsiness, Ataxia (drunk walk), Dizziness, Nausea, Vomiting, Confusion, Headache, Blurred Vision, Skin Rash. Special Attention: if given with other sedatives or hypnotics, Alcohol, dated 06/11/2025. Record review of Resident #2's Order Summary Report, dated 03/06/2026, reflected, Observation: Antianxiety Medication-Observe for behavior (Specify resident's behavior). Observe for side effects: drowsiness, slurred speech, dizziness, nausea, aggressive/impulsive behavior. Document: Y if resident is free of side effects. N if the resident is not free of side effects. If N document SE in the PNs. Every shift for Anti-Anxiety Monitoring. Record review of Resident #2's January 2026 Medication Administration Record reflected Observation: Antianxiety Medication-Observe for behavior (Specify resident's behavior). Observe for side effects: drowsiness, slurred speech, dizziness, nausea, aggressive/impulsive behavior. Document: Y if resident is free of side effects. N if the resident is not free of side effects. If N document SE in the PNs. Every shift for Anti-Anxiety Monitoring. It further reflected LVN C marked N on 01/14/2026 during the day and 01/15/2026 during the day. Record review of Resident #2's progress notes for 01/14/2026 and 01/15/2026 reflected no side effects (continued on next page)</p>		

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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.			
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>were documented. Interview on 03/04/26 at 03:26PM, Resident #2 did not respond to any questions. Resident #2 was observed not having any side effects/behaviors to his antianxiety medication. Interview on 03/06/2026 at 10:38 AM, ADON B revealed the way Resident #2's doctor's orders read was confusing, because they had to document yes for when resident was free of behavior and no if behaviors were observed. She revealed she was not aware of who put the wording in there but that it needed to be changed, because it was affecting nursing documentation. She revealed it would be important to clarify this so there would be less confusion and more accurate documentation. She revealed if Resident #2 had notable behaviors and they were not documenting them correctly; they could not prevent any behaviors as needed. Interview on 03/06/2026 at 03:23PM, LVN C revealed for Resident #2's doctor's orders were confusing with documenting Y for when there were no side effects and N for when Resident #2 did have side effects. He revealed if there were no side effects documented in the progress notes as the doctor's orders states, then he meant to put Y because there were no side effects noted. He revealed when he put no, he meant Resident #2 was not experiencing any side effects. He revealed this should be worded differently for better documentation. Interview on 03/06/26 at 05:29PM, the Senior Director and Regional Nurse revealed the expectation for documentation for medication administration was to document when medication was administered to show the accurate time the medication was administered and that doctor's orders were being followed correctly. They further revealed that sometimes the doctor's orders included documentation to show whether the medications were effective. They revealed they were aware that the doctor's orders for Resident #2 sounded confusing, but they were already working on improvements to the electronic medical record to include better documentation in the medication administration record. Record review of facility's policy Medication Administration, dated 05/09/2025, reflected 20. Sign MAR after administered. 22. Report and document and adverse side effects or refusals.</p>		