STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675896	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Care Center	921 Nolan St San Antonio, TX 78202

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, 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 2 of 7 residents (Residents #2 and #3) reviewed for care plans. The facility failed to update Resident #2's care plan to reflect what type of assistance the resident needed for eating.The facility failed to update Resident #3's care plan that he liked to use [a cleaning agent] to clean his room, but they had to keep this behind the nurse's station for him. This failure could place residents at risk of not having their needs met and not receiving appropriate care.The findings included:Record review of Resident #2's admission record, dated 05/28/26, reflected resident was a [AGE] year-old male, initially admitted [DATE] and re-admitted [DATE], with diagnoses to include burns of various body parts. Record review of Resident #2's quarterly MDS assessment, dated 03/15/26, reflected that resident had a BIMS score of 11 out of 15, indicating moderate cognitive impairment. It further reflected that Resident #2 needed setup or clean-up assistance for eating. Record review of Resident #2's care plan, last care plan review completed 12/07/25, did not reflect resident needed setup or clean-up assistance for eating. Record review of Resident #2's weight history for the last 6 months reflected no significant changes in weight. During an interview on 05/27/2026 at 04:16 PM, CNA C revealed Resident #2 was able to feed himself. During an interview on 05/28/2026 at 04:11 PM, the MDS nurse revealed Resident #2's type of assistance needed for eating was not documented in his care plan. He revealed it was important to know how the resident ate so staff knew how to help Resident #2 with eating. 2. Record review of Resident #3's admission record, dated 05/26/26, reflected resident was a [AGE] year-old male, admitted [DATE], with diagnoses to include major depressive disorder and generalized anxiety disorder. Record review of Resident #3's quarterly MDS assessment, dated 05/09/26, reflected that the resident had a BIMS score of 13 out of 15, indicating intact cognition. Record review of Resident #3's care plan, last care plan review completed 05/14/26, did not reflect that resident could have cleaning supplies/chemical agents in his room for personal use. During an observation on 05/29/26 at 08:33 AM revealed there was [a cleaning agent] on the side of Resident #3's bed. During an interview on 05/29/26 at 08:33AM, LVN A confirmed that Resident #3 had [a cleaning agent] at his bedside. She removed it from his room and revealed he was not allowed to have it in his room. She revealed that they had educated the resident multiple times that he could not have [a cleaning agent] in his room. She revealed she was unsure if it was in his care plan but it could be added. During an interview on 05/29/26 at 08:35 AM, CNA E revealed she had seen [a cleaning agent] in Resident #3's room, but she assumed he was allowed to have it in his room because she was new, because she expected other nursing staff who knew the resident more would take it out of his room because other staff had been providing resident care as well. She revealed it (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would be helpful if this was documented in his care plan so she knew that she should remove [a cleaning agent] from his room when she saw it. During an interview on 05/29/26 at 12:40 PM, the ADM and the DON revealed Resident #3 was okay to have [a cleaning agent] in his room because he was alert and oriented and liked to clean his room on his own. They revealed in order to protect other residents from possibly coming into his room and taking [a cleaning agent] that they were going to document that resident kept [a cleaning agent] in his room despite educating him not to keep it in his room so nursing staff knew to take it out of his room as needed and keep it behind the nurse's station for when he wanted to use it to clean his room. Policies regarding accidents and hazards, prohibited items/items allowed in the facility (to include chemicals/cleaning supplies) were requested from the ADM on 05/29/26 at 09:27 AM and the ADM did not have these policies. Record review of the facility's policy Comprehensive Care Planning, undated, reflected .The comprehensive care plan will describe the following-The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #3) out of 7 residents reviewed for accidents and supervision. The facility failed to ensure Resident #3 did not have [a cleaning solution] at bedside on 05/28/26 and 05/29/26. These failures could place residents at risk for negative adverse effects. Findings included: Record review of Resident #3's admission record, dated 05/26/26, reflected resident was a [AGE] year-old male, admitted [DATE], with diagnoses to include major depressive disorder and generalized anxiety disorder. Record review of Resident #3's quarterly MDS assessment, dated 05/09/26, reflected that resident had a BIMS score of 13 out of 15, indicating intact cognition. Record review of Resident #3's care plan, last care plan review completed 05/14/26, did not reflect that resident could have cleaning supplies/chemical agents in his room for personal use. Observation on 05/28/26 at 08:12 AM revealed Resident #3 had [a cleaning agent] on the side of his bed. During an interview and observation on 05/29/26 at 08:33 AM, LVN A confirmed that Resident #3 had [a cleaning agent] at his bedside. She removed it from his room and revealed he was not allowed to have it in his room. During an interview on 05/29/26 at 08:35 AM, CNA E revealed she had seen [a cleaning agent] in Resident #3's room, but she assumed he was allowed to have it in his room because she was new, because she expected other nursing staff who knew the resident more would take it out of his room because other staff had been providing resident care as well. She further revealed she knew [a cleaning agent] should not be in a resident's room to keep residents safe. During an interview on 05/29/26 at 12:40 PM, the ADM and the DON revealed Resident #3 was okay to have [a cleaning agent] in his room because he was alert and oriented, but in order to protect other residents they were going to put it in his care plan that him and his family bring in cleaning agents despite education, so nursing staff could monitor his room and keep any cleaning agents behind the nurse's station. During an interview on 05/29/26 at 02:10 PM, the DON revealed it was important to not give residents that may not be alert and oriented access to cleaning agents to keep them safe. During an interview on 05/29/26 at 02:18 PM, the ADM revealed that they did not have any residents that wandered into other residents' rooms at this facility. She revealed the facility did not have to worry about a resident going into Resident #3's room so residents remained safe because they could not get the cleaning agent.Policies regarding accidents and hazards, prohibited items/items allowed in the facility (to include chemicals/cleaning supplies) were requested from the ADM on 05/29/26 at 09:27 AM and the ADM did not have these policies.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident received and the facility provided food that accommodates residents' food preferences and food allergies for 2 of 7 residents (Resident #1 and Resident #2) reviewed for food preferences and food allergies.The facility failed to ensure Resident #1 received orange juice per her 05/28/26 breakfast meal tray ticket.The facility failed to ensure that Resident #2's 05/28/26 lunch meal tray ticket reflected that he had a lactose allergy. This failure could place residents at risk for a decline in health status or an allergic reaction due to inadequate or inappropriate nutritional intake, respectively. The finding included:Record review of Resident #1's admission record, dated 05/27/26, reflected resident was an [AGE] year-old female, admitted [DATE], with diagnoses to include dementia (loss of cognitive functioning that interferes with daily life and activities). Record review of Resident #1's quarterly MDS assessment, dated 03/25/26, reflected that resident had a BIMS score of 04 out of 15, indicating severe cognitive impairment. Record review of Resident #1's care plan, undated, reflected a focus of [Resident #1] has nutritional problem dementia, requires frequent redirection, initiated 10/02/25, with intervention Provide and serve diet as ordered, initiated 10/23/25. Record review of Resident #1's weight history for the last 6 months reflected no significant changes in weight. During an interview, observation, and record review of Resident #1's 05/28/26 breakfast tray ticket at 08:18 AM, revealed her tray ticket reflected orange juice. Observation of her breakfast meal revealed apple juice was served instead of orange juice. During an interview, Resident #1 revealed she did like orange juice, but she was okay with the apple juice today and that sometimes she did not receive everything on her tray ticket, but she was able to ask the nursing staff for what she wanted to eat. During an interview on 05/28/26 at 08:26 AM, LVN A revealed Resident #1's 05/28/26 breakfast tray did not include orange juice, but the resident was able to voice if she wanted something else to eat or drink. She revealed nurses oversaw the meal tray tickets matching the meals served and they had to work with the kitchen to get the correct foods that were reflected on the meal tray tickets. She revealed sometimes the kitchen did not serve foods that were on the tray tickets. She revealed it was important to follow tray tickets to follow preferences, dislikes, and allergies. She revealed following residents' diets was important as their diets were based on their health conditions like diabetes. During an interview on 05/28/26 at 08:39 AM, [NAME] B revealed when a tray ticket had orange juice on it, they could put any juice on the resident's tray instead. She revealed she did not know why the tickets did not just have juice instead of orange juice on the residents' tray tickets. She revealed it was important to follow residents' tray tickets so that the residents received what they wanted. During an interview on 05/28/26 at 08:42 AM, the Dietary Manager revealed meal tray tickets should be followed to meet the residents' needs. He revealed the kitchen had orange juice and they should have served residents orange juice if it was on their tray ticket. He further revealed it was every kitchen staff's responsibility to ensure the meals being served matched the meal tray tickets. 2. Record review of Resident #2's admission record, dated 05/28/26, reflected resident was a [AGE] year-old male, initially admitted [DATE] and re-admitted [DATE], with diagnoses to include burns of various body parts. It further reflected that the resident had a lactose allergy. Record review of Resident #2's quarterly MDS assessment, dated 03/15/26, reflected that resident had a BIMS score of 11 out of 15, indicating moderate cognitive impairment. Record review of Resident #2's care plan, last care plan review completed 12/07/25, reflected Resident #2 had a lactose allergy Record review of Resident #2's weight history for the last 6 months reflected no significant changes in weight. During an interview and record review on 05/28/26 at 03:28 PM, Resident #2 revealed his lunch meal tray ticket did not state that he had an allergy to lactose as was reflected in his electronic medical record. Resident #2 revealed he was lactose intolerant but still received milk on his meal trays. He (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed he knew to not eat or drink products that had lactose, but it would be helpful if the kitchen did not give him those food products. During an interview on 05/28/26 at 03:35 PM, the Dietary Manager revealed he did not know that Resident #2 was allergic to lactose, but he would get that information from nursing so he could put that on the tray ticket, so the resident did not receive anything they were allergic to. During an interview on 05/28/26 at 03:39 PM, CNA C revealed he was not aware that Resident #2 was allergic to lactose because Resident #2 was served foods that had lactose and it was good to know now. He noticed Resident #2 did not drink lactose products, so it made sense. During an interview on 05/28/2026 at 04:11 PM, the DON revealed they confirmed with Resident #2 that he had a lactose intolerance. She revealed she was unaware of when lactose allergy was reflected in his electronic medical record and it should be on his meal tray tickets. During an interview 05/28/2026 at 04:34 PM, the ADM and DON revealed it was important to follow meal tray tickets to ensure they have the right diet, right texture, and right resident. During an interview on 05/29/26 at 11:56 AM, the RD reviewed Resident #2's electronic medical record remotely and his nutrition related assessments did not reflect Resident #2 having a lactose allergy. She revealed Resident #2's lactose allergy was on his face sheet but she was not aware of when that was there because in his interviews he never mentioned having a lactose allergy. She revealed it may have been a miss on our part and she was unaware of who communicated residents' allergies to the kitchen to put it on their meal tray ticket so that everyone involved in his care knew what foods to serve him and prevent problems due to allergies. During an interview on 05/29/2026 at 01:38 PM, the DON revealed Resident #2's lactose allergy should have been communicated to the dietary department. She revealed nursing staff could do that, and it was important in order for residents to not have reactions with foods. Record review of the facility's policy Food Preference List, dated 2012, reflected . 2. Information should be obtained by interview on all new residents. 3. Tray cards are to be updated at least quarterly and reflect appropriate information from food preferences. Generally, the dislikes are the most relevant on the tray card. Record review of the facility's policy Resident Meal Service and HS Snack, dated, reflected 1. Upon admission and periodically thereafter, the resident and/or family member will be interviewed by the dietary manager or designee to determine individual food preferences, dislikes, and allergies.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food for 1 of 1 kitchen in accordance with professional standards for food service safety. 1. The facility failed to fill out the night temperatures for 2 freezers and 1 refrigerator on May 2026 temperature log for 05/27/26.2. The facility failed to store sliced cheese in a sealed container on 05/28/26.3. The facility failed to label a bag of onions and bell peppers with a discard date on 05/28/26.4. The facility failed to ensure there was not a personal beverage in the food preparation area on 05/28/26. These failures could place residents at risk for food borne illness. The findings included: During an observation and interview on 05/28/26 at 08:39 AM revealed there was a missing temperature for 2 freezers and 1 refrigerator on May 2026 temperature log for 05/27/26 night temperature. [NAME] B revealed it was important to have the temperature logs up to date to ensure no food went bad. During an observation and interview on 05/28/26 at 08:42 AM, revealed there was a bag of sliced cheese in the walk-in refrigerator that was not sealed and exposed to air. In the walk-in refrigerator, it was further revealed there was a bag of onions and bell peppers with no discard/use-by date. The Dietary Manager and [NAME] B revealed foods that were stored in the refrigerator should have a discard date and be in a sealed bag to ensure the foods that were used for residents' meals were not old or became hard. The Dietary Manager revealed temperatures needed to be documented to ensure proper food storage. The Dietary Manager revealed all kitchen staff could ensure temperatures were recorded and food was stored properly but he oversaw everything. During an interview and observation on 05/28/26 at 11:34 AM, revealed there was a personal beverage (open clear cup of fluid) in the food preparation area while [NAME] B was prepping 05/28/26 lunch. [NAME] B and the Dietary Manager revealed the personal beverage should not be in the food preparation area to prevent cross contamination and it belonged to Dietary Aide D. During an interview on 05/28/26 at 11:37 AM, Dietary Aide D confirmed that he did have a personal beverage in the food preparation area, but he had just poured it and left the kitchen. He revealed he should not have a personal beverage in the food preparation area because it could cause cross contamination. Record review of the facility's policy Daily Food Temperature Control, dated 2012, reflected . 3. Temperatures are recorded on the Temperature Log form . Record review of the facility's policy Refrigerator/Freezer Temperature Log (Instructions), dated 2012, reflected 1. Dietary Services Manager will be the person responsible for making sure the temperature of the refrigerator/freezer is recorded on a daily basis. 7. Take temperatures at the same time every morning and evening. Record review of the facility's policy Food Storage and Supplies, dated 2012, reflected . 4. Open packages of food are stored in closed containers with covers or in sealed bags. Record Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 3-305.11, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposited to splash, dust, or other contamination. Record review of the FDA Food Code 2022, U.S. Department of H&HS, reflected, 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1