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	07/02/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure, in accordance with accepted professional standards and practices, that medical records were accurately documented and complete for each resident, for 1 of 4 residents (Resident #1) reviewed for the accuracy of their medical records. The facility failed to ensure the accuracy and completeness of the resident's clinical record by failing to document controlled substance administration on the MAR after the medication had been signed out on the controlled substance record. This resulted in discrepancies between the residents' MAR and the narcotic accountability records. This failure could place residents at risk of receiving improper care.Record review of Resident #1's face sheet, dated 7/1/2026, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Depression (a mental health condition where a person feels very sad, hopeless), Chronic Pain (is ongoing pain that lasts longer than expected and continues for months or years), and Chronic Obstructive Pulmonary Disease (Is a disease that makes it difficult to breathe because the lungs do not work as well as they should). Record review of Resident #1's BIM'S assessment, completed 4/4/26, revealed a BIM'S score of 15, which indicated intact cognition. Record review of Resident #1's care plan, updated 12/22/2023, revealed an intervention of administer medications as ordered. Record review of Resident #1's monthly physician orders for June 2026 revealed an order for Oxycodone oral tablet 10 mg, to be administered every 6 hours as needed for pain. Record review of Resident #1's controlled substance administration log, undated, revealed that an Oxycodone 10 mg tablet had been signed out on 6/15/2026 at 4:30 AM, 10:30 AM, and 4:30 PM. Record review of Resident #1's MAR administration report for June 2026 revealed no documentation of Oxycodone tablet 10 mg. Interview with Resident #1 on 7/1/2026 at 2:00 PM; stated he was not 100% sure whether he received an Oxycodone tablet, 10 mg, on 6/15/2026 at 4:30 AM, 10:30 AM, and 4:30 PM. Group interview conducted on 7/2/2026 at 11:30 AM with LVN A, LVN B, and LVN C revealed LVN A was the night nurse, LVN B the day nurse, and LVN C the evening nurse on 6/15/2026. Each nurse reported administering a 10 mg Oxycodone tablet as recorded on the controlled substance administration log. They acknowledged that they did not document this administration on MARS due to human error. All nurses recognized that failing to document on the MARS while recording only in the controlled substance log could hinder other staff from verifying medication administration. During, interview on 7/2/2026 at 1:00 PM , the DON confirmed knowing that nursing staff have not recorded controlled substances on the medication administration record after signing them out on the narcotic count record. She admitted this causes incomplete and inaccurate clinical documentation. Her plan to fix this includes retraining licensed nursing staff in proper documentation, checking MARs and narcotic records for accuracy and completeness, and establishing ongoing checks to ensure compliance and prevent recurrence. Record review of the facility's undated documentation policy revealed: The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.

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