

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675896	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/10/2025
NAME OF PROVIDER OR SUPPLIER  River City Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 out of 8 residents (Resident #12) reviewed for abuse/neglect as evidenced by: The facility failed to ensure Resident #12 was free from abuse when CNA A squirted Resident #12 with a water gun in her mouth while she slept on 5/24/25. The facility failed to ensure Resident #12 was free from abuse when Resident #12 made an allegation of abuse by CNA C. The allegation was reported to the Administrator on 05/31/2025 by CNA C and on 06/19/2025 by HHSC Surveyor L. An Immediate Jeopardy (IJ) was identified on 07/08/2025 at 4:40 p.m. The IJ template was provided to the facility on [DATE] at 5:06 p.m. While the IJ was removed on 07/10/2025 at 4:10 p.m., the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of its Plan of Removal (POR). This failure could place residents at risk of abuse, injury, and psychosocial harm. Findings included: 1). Record review of Resident #12's admission record, dated 6/18/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #12 had diagnoses which included: type 2 diabetes mellitus chronic kidney disease (disease that affects how the body uses blood sugar), seizures (sudden surge of abnormal electrical activity in the brain), COPD (chronic obstructive pulmonary disease is a lung condition caused by damage to the lungs), and dementia (loss of cognitive functioning). Record review of Resident #12's quarterly MDS, dated [DATE], revealed the resident had severely impaired cognition for daily decision-making skills with a BIMS score of 5. Record review of Resident #12's care plan, dated 06/18/2025, reflected Resident #12 had impaired cognitive function/dementia or impaired thought process, BIMS score severe cognitive impairment, and at times resident made statements that were far from reality or are nonsensical, with an initiated date of 01/16/2025, and revised on 06/06/2025. Record review of the facility's investigation report, dated 06/04/2025, stated On the afternoon of 05/28/2025, CNA [B] reported to Administrator's office with ., Business Office Manager/HR informing that resident [#12] stated that on Saturday, 5/23 [sic], CNA [A] had dropped the bed remote on her left arm. She reported that, when she told him not to do that again, he stated that he would do it as many times as he wanted. Later that day while she was taking a nap, [Resident #12] reported that [CNA A] entered her room and woke up her by shooting a water gun in her mouth .Record review of witness statement summaries: [CNA A] stated that he works weekends only. He denied ever dropping a remote on [Resident #12]'s arm or making statements about continuing to do so despite the protest. When asked if he had ever brought a water gun to work, he stated that he had only squirted residents with it in the kitchen area. He denied squirting [Resident #12] or having the water gun in her room. [Resident #33] a resident in the same section of hallway/CNA assignment as the alleged victim, was asked if she knew [CNA A]. She confirmed that he was her CNA .When asked if she had ever seen him with a water gun, she stated that he had brought one into her room recently and squirted her with it while she laid in bed. She reported that she was not bothered by this act but did think it bizarre behavior.[Resident #16] a resident on the same section of hallway/CNA assignment as the alleged victim, acknowledged that he knew [CNA A] as his weekend CNA. He confirmed that [CNA A] had brought a water gun to the facility and squirted him with it while in his room. He did not feel negatively toward this act and asked that [CNA A] not get in no trouble for this behavior . During an interview on 06/18/2025 at 11:44 a.m. Resident #12 stated she was terrified and scared when she awoke in her room to CNA A splashing water into her mouth with a pistol. Resident #12 stated CNA A had dropped a remote on her arm that caused her pain earlier that day and she told him not to do that again. Resident #12 stated CNA A told her he would do it as many times as he wanted. Resident #12 stated she reported the incident to CNA B on 05/28/2025. During an interview on 06/19/2025 at 12:08 p.m. CNA D stated she knew of an outdoor water activity where they threw water balloons but never saw or knew of any activities that involved water guns. CNA D stated no residents ever reported to her being squirted with a water gun. CNA D stated Resident #12 hallucinated before, but they did a UA (urine analysis), and she had a UTI. During an interview on 06/19/2025 at 1:01 p.m. CNA A stated there was an outdoor activity Resident #12 was never involved in and the water gun was left over from the facility activity. He stated he never sprayed any residents with a water gun only other staff in the dining room area .CNA A stated Resident #33 vouched for him that he never sprayed any residents with the water gun</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 2 of 3 medication cart (west medication cart and nursing treatment cart) and 1 of 2 medication (west medication storage room) storage rooms reviewed for storage of drugs.</p> <ol style="list-style-type: none"> <li>The facility failed to ensure the west medication cart did not have loose pills and did not have an insulin vial with no open date.</li> <li>The facility failed to ensure the west hall medication storage room fridge had a permanently affixed narcotic lock box. The box contained vials of liquid lorazepam (controlled benzodiazepine tranquilizer medication used to treat anxiety or seizures).</li> <li>The facility failed to ensure the nurse treatment cart did not store the keys to the cart on the cart.</li> </ol> <p>This deficient practice could place residents at risk of medication misuse and diversion.</p> <p>The findings were:</p> <ol style="list-style-type: none"> <li>Observation and interview on 6/20/25 at 9:35 a.m. revealed the west medication cart had two loose white pills and two loose pink pills in the top drawer. A vial of insulin belonging to Resident #23 did not have an open date on the vial. LVN E stated she was unsure where the pills came from or what they were. LVN E stated any loose pills should be discarded, not administered to residents, and threw them in the sharp's container. LVN E stated the insulin vials should have an open date written on the box and vial in case the box and vial get separated and you do not know when it was opened.</li> </ol> <p>During an interview on 6/20/25 at 1:28 p.m. the DON stated there should not be loose pills in the medication storage carts because they do not know what they are, and they should not be used. The DON stated staff were expected to label both the insulin vial and the box with an open date in case they get separated.</p> <ol style="list-style-type: none"> <li>During an observation on 6/20/25 at 9:58 a.m. the west hall medication storage room contained a refrigerator for resident medications. Inside the fridge was a plastic box with a chain. The chain was connected to the inside of the fridge with a pad lock. The pad lock was not completely closed and the screws that secured the bracket to the fridge were weak, and came loose and unscrewed when the pad lock was manipulated. Resident's liquid lorazepam was in the cold narcotic storage box.</li> </ol> <p>During an observation and interview on 6/20/25 at 10:28 a.m. the DON demonstrated the lock was not fully closed or engaged but could not be opened. When the DON manipulated the pad lock one screw came out of the side of the fridge. The DON stated the nurses had the keys to the pad lock inside the fridge. The DON stated she was not sure why it was not fully locked but the way it was you could not turn the lock to open it. The DON stated she thought the box was still permanently affixed inside the fridge.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. During an observation on 6/20/25 at 1:49 p.m. the nursing treatment cart had a white container on the side of it. LVN F walked up to the cart grabbed the container, opened it, took the keys to the cart out, and unlocked the cart. LVN F stated residents did not know they keys were in the container to open the cart.</p> <p>During an interview on 6/20/25 at 1:53 p.m. the DON stated the key for the nursing treatment cart were not in the line of sight and residents did not know it was there. The DON stated it was acceptable to have the keys in an unlocked container on the cart.</p> <p>Record review of the facility's policy titled Medication Storage in the Facility, dated 2025, stated: Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications .9. Each States rule vary on securing the classes of controlled substances the facility will adhere to their individual State's rules as it relates, some states require that ALL classes of controlled substances be stored in the lock-box located in the medication cart to adhere to the required double locked/secured storage .13. outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures. are immediately removed from stock, disposed of according to the procedures for medication destruction .</p> <p>Record review of the facility's policy titled Recommended Medication Storage, dated 7/2012, stated Medications that require an open date as directed by the manufacturer should be dated when opened in a manner that it is clear when the medication was opened. Below is a list of medications that require a date when opening and the recommended time frame the medication should be used. This is not an all-inclusive list and the manufacturer recommendations will supersede this list .INSULINS (Vials, Cartridge, Pens) .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with profession standards for food service safety for 1 of 1 facility in that:</p> <ol style="list-style-type: none"> <li>1. The facility failed to clean a ceiling vent.</li> <li>2. The facility failed to clean a side wall panel air vent.</li> <li>3. The facility failed to date an opened jar on mayonnaise in the refrigerator.</li> <li>4. The facility failed to date two bags of cookie pieces in the storage room.</li> <li>5. The facility failed to maintain a dish machine sanitation unit.</li> </ol> <p>These failures could place residents at risk for food borne illness.</p> <p>The findings included:</p> <p>Observation on 06/17/2025 from 9:15am until 9:45am with the Food Service Director revealed the following:</p> <ol style="list-style-type: none"> <li>a. There was a 3x2 foot overhead ceiling vent in the main kitchen area that was covered with dirt and dust particles.</li> <li>b. There was a 3x3 foot side wall ceiling vent next to the dish machine that was covered with dirt and dust particles.</li> <li>c. There was an opened one gallon jar of mayonnaise in the refrigerator that was not dated.</li> <li>d. There were 2 bags of 2 gallon size Oreo piece cookies in the storage room that were not dated.</li> <li>e. The dish machine did not record the sanitizer concentrate level after the dish machine cycle.</li> </ol> <p>During an interview on 06/17/25 at 9:50am, the Food Service Director stated the dirty ceiling and side wall vents did not allow a clean kitchen environment to be maintained The Food Service Director stated food items in the refrigerator and storage room had to be labeled for use by dates to be followed. The Food Service Director stated he was unaware of the dish machine sanitizer not working after each wash cycle and it was working properly the day before which was confirmed. The Food Service Director stated the sanitizer unit on the dish machine would be immediately fixed. He stated that the dish machine's use of the sanitizer was necessary for proper cleaning of dishware.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Administrator on 6/17/25 at 10:00am stated that the dirty ceiling and side wall vents would be cleaned for a clean kitchen environment. She stated that dating of all food was necessary for the use by dates to be followed. The Administrator stated that the dish machine sanitizer unit would be immediately fixed and a same day repair by the dish machine service vendor was confirmed.</p> <p>During an interview with the Maintenance Director on 6/18/25 at 7:25am stated he had not received a previous work order to clean the ceiling and side vents in the kitchen.</p> <p>Record review of facility policy entitled Cleaning Schedules in the Dietary Services Policy and Procedure Manual dated 2012 stated The Dietary department and all equipment in the dietary department will be cleaned on a regular scheduled basis.</p> <p>Record review of the facility policy entitled Left-Over Foods in the Dietary Services Policy and Procedure Manual dated 2012 stated Left-over foods shall be refrigerated, dated, label and properly covered promptly after meal service.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1 of 8 residents (Resident #21) reviewed for infection control:</p> <p>The facility failed to ensure Resident #21's indwelling urinary catheter bag was not on the floor.</p> <p>These failures could place residents at-risk for infection due to improper care practices.</p> <p>The findings included:</p> <p>Record review of Resident #21's face sheet dated 6/20/25 revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included sepsis due to streptococcus pneumoniae (life threatening condition that arises when the body's response to infection can cause tissue damage, organ failure, or even death), urinary tract infection (infection of the urinary tract), vesicoureteral-reflux with reflux nephropathy with hydroureter, bilateral (condition where urine flows backwards from the bladder to both ureters (muscular tubes that transport urine from the kidneys to the bladder)), dementia, and Parkinson's disease without dyskinesia (progressive movement disorder of the nervous system).</p> <p>Record review of Resident #21's significant change MDS assessment, dated 6/3/25, revealed the resident cognition was severely impaired for daily decision-making skills, required substantial assistance with bed mobility and transfers and utilized a catheter.</p> <p>Record review of Resident #21's Physician Order, dated 6/20/25, revealed the following:</p> <p>-Ensure foley bag is in privacy bag while in bed or wheelchair every shift, with a start date of 6/1/25, and no end date.</p> <p>-may change foley catheter using 16 fr 10mL bulb if leaking or blockage as needed for foley care, with a start date of 6/1/25, and no end date.</p> <p>Record review of Resident #21's comprehensive care plan revealed a care area, initiated 6/13/25, the resident had an indwelling catheter due to recurrent UTI infection and neurogenic bladder with interventions to Position catheter bag and tubing below the level of the bladder and in a privacy bag, and check tubing for kinks and maintain the drainage bag off the floor.</p> <p>Observation on 6/17/25 at 11:20 a.m. revealed Resident #21 was in bed sleeping and the indwelling urinary catheter draining to gravity on the left side of the bed. The catheter bag was visible from the doorway. The catheter bag was not in a dignity bag and was touching the floor.</p> <p>During an interview on 6/19/25 at 12:05 p.m., CNA D stated catheter bags should be inside a dignity bag and have a basin under them. CNA D stated a dignity bag and basin were added to the resident's catheter bag, but she was unsure who fixed it. CNA D stated the catheter bag needed a dignity bag and or basin so contamination from the floor would not happen or so no one could step on the bag.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/20/25 at 1:25 p.m., the DON stated the indwelling urinary catheter bag should not be touching the floor because there was a potential for infection. The DON stated there was a basin and dignity bag on the catheter at that time and someone probably moved it the other day.</p> <p>Record review of the facility policy titled Catheter Care, dated 2/13/2007, stated General Guidelines .10. 10. Be sure the catheter tubing and drainage bag are kept off the floor .</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>Based on interview and record review, the facility failed to provide the required 80 square feet per resident in 45 of 46 resident rooms (Rooms #2-5, #7, #9-30, #32, #34, #36-51) reviewed for bedroom measurement .</p> <p>The facility failed to ensure rooms measured the required 80 square feet per resident.</p> <p>This failure could impede the ability of residents living in these rooms to attain their highest practicable well-being.</p> <p>Findings included:</p> <p>During an interview on 6/18/25 at 4:00pm with Life Safety Inspector-G stated that all of the room measurements were taken for the listed rooms.</p> <p>Rooms:</p> <p>#2 (146) 73 square feet with 2 beds in the room</p> <p>#3 (147) 73.5 square feet with 2 beds in the room</p> <p>#4 (147.6) 73.8 square feet with 2 beds in the room</p> <p>#5 (147.1)73.5 square feet with 2 beds in the room</p> <p>#7 (147) 73.5 square feet with 2 beds in the room</p> <p>#9 (146.3) 73.1 square feet with 2 beds in the room</p> <p>#10 (146.3) 73.15 square feet with 2 beds in the room</p> <p>#11 (147.1) 73.5 square feet with 2 beds in the room</p> <p>#12 (147.1) 73.5 square feet with 2 beds in the room</p> <p>#13 (146.9) 73.4 square feet with 2 beds in the room</p> <p>#14 (146) 73 square feet with 2 beds in the room</p> <p>#15 (145.77) 72.82 square feet with 2 beds in the room</p> <p>#16 (145.77) 72.82 square feet with 2 beds in the room</p> <p>#17 (146.27) 73 square feet with 2 beds in the room</p> <p>#18 (145.23) 72.62 square feet with 2 beds in the room</p> <p>(continued on next page)</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>#19 (145.23) 72.62 square feet with 2 beds in the room</p> <p>#20 (145.23) 72.62 square feet with 2 beds in the room</p> <p>#21 (145.53) 72.76 square feet with 2 beds in the room</p> <p>#22 (148.403) 74.20 square feet with 2 beds in the room</p> <p>#23 (147.811) 73.91 square feet with 2 beds in the room</p> <p>#24 (148.282) 74.14 square feet with 2 beds in the room</p> <p>#25 (147.465) 73.73 square feet with 2 beds in the room</p> <p>#26 (148.664) 74.33 square feet with 1 bed in the room</p> <p>#27 (147.919) 73.96 square feet with 2 beds in the room</p> <p>#28 (146.937) 73.47 square feet with 2 beds in the room</p> <p>#29 (147.571) 73.79 square feet with 2 beds in the room</p> <p>#30 (152.176) 76.09 square feet with 2 beds in the room</p> <p>#32 (158.190) 79.10 square feet with 2 beds in the room</p> <p>#34 (149.669) 74.83 square feet with 2 beds in the room</p> <p>#36 (148.516) 74.26 square feet with 2 beds in the room</p> <p>#37 (155.894) 77.95 square feet with 2 beds in the room</p> <p>#38 (140.45) 70.23 square feet with 2 beds in the room</p> <p>#39 (147.921) 73.96 square feet with 2 beds in the room</p> <p>#40 (147.244) 73.62 square feet with 2 beds in the room</p> <p>#41 (149.234) 74.62 square feet with 2 beds in the room</p> <p>#42 (157.707) 78.85 square feet with 2 beds in the room</p> <p>#43 (160.834) 80.42 square feet with 2 beds in the room</p> <p>#44 (157.169) 78.58 square feet with 2 beds in the room</p> <p>#45 (157.169) 78.58 square feet with 2 beds in the room</p> <p>(continued on next page)</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>#46 (155.038) 77.52 square feet with 2 beds in the room</p> <p>#47 (153.302) 76.65 square feet with 2 beds in the room</p> <p>#48 (153.728) 76.86 square feet with 2 beds in the room</p> <p>#49 (149.055) 74.53 square feet with 2 beds in the room</p> <p>#50 (148.311) 74.311 square feet with 2 beds in the room</p> <p>#51 (159.466) 79.73 square feet with 2 beds in the room</p> <p>Record review of the Provider History Profile which was updated on 4/8/24 revealed an existing room size waiver from the re-certification survey with an exit date of 4/08/24.</p> <p>Interview and record review with the Administrator on 6/19/25 at 4:00pm provided a signed Form 3762-Room Size Waiver request form dated 6/4/25. The Administrator stated that the facility requested the same room size waiver be continued for the next year. The Administrator stated there had been no change in the number or size dimensions of the affected rooms requested for waiver consideration.</p>