STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676256	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Remo	3550 N Shiloh Rd Richardson, TX 75082

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat each resident with respect, dignity, and care in a manner and environment that promotes maintenance or enhancement of his or her quality of life for one (Resident #113) of eight residents reviewed for resident rights.The facility failed to treat Resident #113 with dignity and promote enhancement of his quality of life when the resident was not provided privacy for his nephrostomy bags (collects urine from the urinary bladder) on 02/17/2026.This failure could place residents at risk of not having their right to a dignified existence maintained and a decline in their quality of life.Findings included: Record review of Resident #113's Face Sheet, dated 02/17/2026, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed malignant (conditions that are dangerous to health) neoplasm (abnormal growth of tissue in the body) of the prostate.Record review of Resident #113's Comprehensive MDS (assessment used to determine functional capabilities and health needs) Assessment, dated 02/08/2026, reflected the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS (screening tool used to assess cognitive status) score of 13. The Comprehensive MDS Assessment indicated the resident had a nephrostomy tube (thin, flexible catheter inserted through an incision in the kidney).Record review of Resident #113's Comprehensive Care Plan, dated 02/03/2025, reflected the resident did not have a care plan for his nephrostomy tubes nor a plan about non-compliance of putting the nephrostomy bags (external medical device that collects urine directly from the kidney) inside his pants.Record review of Resident #113's Physician's Order, dated 02/04/2026, reflected Nephrostomy (medical procedure that creates an artificial opening between the kidney and the skin to allow urine to drain) Care every day shift Clean skin around Nephrostomy tube(s) with soap and water, pat dry and apply dressing as ordered.During an observation on 02/17/2026 at 11:15 AM revealed Resident #113 was inside his room with a family member. The resident had two nephrostomy bags that were placed outside his pants. The bags and the urine inside the bags could be seen from the hallway. Record review of Resident #113's Progress Notes, dated 02/04/2026 to 02/17/2026, reflected no documentation that the resident refused to put his nephrology bags inside his pants.During an interview on 02/17/2026 at 11:21 AM, CNA F stated Resident #113's nephrostomy bags had always been placed outside his pants since he was admitted to the facility. She said that was how the resident and the family member wanted it. She said the nephrostomy bags were outside the resident's pants even when he walked in the hallways or when he went to the dining area. She said, by right, the resident's bags should not be visible to others to avoid embarrassment in case a visitor would come or would pass by. During an interview on 02/17/2026 at 11:30 AM, Resident #113 stated he never told anybody he wanted his urine bags out in the open. He said nobody talked to him that his bags needed to be inside his pants so it would not be visible to others. During an interview on 02/17/2026 at 11:32 AM, Resident #113's family member stated that nobody from the facility talked to her (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Resident #113 about putting the nephrostomy bags inside the pants. The family member said that she preferred the bags to be inside the resident's pants for dignity issue, but nobody talked to them about it. She said it could be embarrassing if everybody could see his urine. She said if somebody from the facility talked about it, then she could have raised some questions how it would be easier for the staff to empty the bags.During an interview on 02/17/2026 at 12:23 PM, ADON A stated she put a care plan about resident #113's non-compliance with covering the nephrostomy bags only when somebody started asking questions why they were outside the resident's pants. ADON A said she did not talk to the resident and the family member about placing the bags inside the pants to provide dignity.During an observation on 02/17/2026 at 1:56 PM revealed Resident #113 was inside his room. It was observed that the nephrostomy bags were not outside the resident's pants.During an interview on 02/19/2026 at 6:44 AM, the DON stated the resident had the right to refuse if he did not want his nephrostomy bags inside his pants. When told per the family member that nobody talked to them about putting the bags inside the pants and that the staff only put the care plan for non-compliance when somebody started asking why the bags were exposed, the DON did not reply.During an interview on 02/19/2026 at 8:06 AM, the Administrator stated that the nephrostomy bags should be not visible from the hallway or should not be outside his pants when walking down the hall to provide dignity. He said the expectation was for the staff to explain to the resident about putting the bags inside his pants. He said they would re-educate the staff about providing dignity to the residents. Record review of the facility's policy, Resident Rights undated, reflected The resident has the right to a dignified existence.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 10 of 20 resident rooms (Rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10) observed for cleanliness. The facility failed to ensure Rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10 were thoroughly cleaned and sanitized. This facility failure could place residents at risk of living in an unclean and unsanitary environment, leading to a decreased quality of life.Findings included: During an observation on 02/17/26 at 11:10 a.m., revealed room [ROOM NUMBER]'s the air conditioning unit had black dirt and dust between the vents and the air filter had thick dust. Observation revealed the bathroom floor had thick dark substances near the toilet. During an observation on 02/17/26 at 11:23 a.m., revealed room [ROOM NUMBER]'s air conditioning unit had black dirt and dust on the front of the unit and between the vents. The air filter had thick dust. During an observation on 02/17/26 at 11:29 a.m., revealed room [ROOM NUMBER]'s air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The air filter had thick dust. The shower floor had thick soap scum and rust like stains. During an observation on 02/17/26 at 11:34 a.m., revealed room [ROOM NUMBER]'s air conditioning unit had black dirt and dust all over the front of the unit and between the vents. The air filter had thick dust. The bathroom floor had a pair of disposable gloves in a corner of the bathroom, near the toilet. During an observation on 02/17/26 at 11:40 a.m., revealed room [ROOM NUMBER]'s air conditioning unit reflected black dirt and dust all over the front of the unit and between the vents. The bedside table had stains all over the lower frame. The shower floor had thick soap scum and rust like stains. During an observation on 02/17/26 at 11:52 a.m., revealed room [ROOM NUMBER]'s bathroom floor had dark substances in the corners of the floor behind the toilet. During an observation on 02/17/26 at 11:59 a.m., room [ROOM NUMBER]'s air conditioning unit had black dirt and dust on the front of the unit and between the vents. The shower floor had a thick grayish substance. During an observation on 02/17/26 at 12:26 p.m., revealed room [ROOM NUMBER]'s air conditioning unit had black dirt and dust on the front of the unit and between the vents. The air filter had thick dust. The carpeted room floor had a large dark stain near the center of the room. The bedside table had red stains all over the lower frame. During an observation on 02/17/26 at 12:39 p.m., revealed room [ROOM NUMBER]'s air conditioning unit had black dirt and dust on the front of the unit and between the vents. The air filter had thick dust. The carpeted room floor had reddish stains along the front of the miniature fridge. During an observation on 02/17/26 at 12:54 p.m., revealed room [ROOM NUMBER]'s carpeted room floor had a large white stain near the center of the room.During an interview on 02/19/26 at 10:49 a.m., Housekeeping E stated he had been at the facility for two years. He stated they were supposed to clean the entire room, including the air condition units. He stated they were to also clean the entire bathroom. He stated he was responsible for cleaning the 700- hall. He was shown pictures of the concerns observed by the surveyor in Rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10. He stated the floor tech was supposed to clean the carpets and he had pointed it out to them, but they had not cleaned it. He stated he was responsible for cleaning the areas and if not cleaned properly could result in respiratory problems.During an interview on 02/29/26 at 11:02 a.m., Housekeeping N stated she had been at the facility for nearly 2 years. She stated she sometimes cleaned the 400-hall. She stated they were supposed to clean the entire room. She was shown pictures of the concerns observed by the surveyor in Rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10. She stated (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she did not clean the air filters, but she was responsible for cleaning all the other areas. She stated the rooms not being thoroughly cleaned could have a negative impact on the residents.During an interview on 02/19/26 at 11:16 a.m., Floor Tech J stated he had just started at the facility. He stated he was responsible for cleaning the floors. He stated he walked around to check carpets for any spots he may have observed in the residents' rooms. He was shown photos of Rooms #8 and #10, and he stated he had shampooed the carpet for room [ROOM NUMBER] on 02/18/26. He stated his supervisor had instructed him to clean it. He stated the supervisor normally provided him a list of floors to clean and if a stain was reported to the supervisor, the supervisor would notify him. He stated if he was a resident or family member, he would not like to see those stains.During an interview on 02/19/26 at 11:27 a.m., the Housekeeping Supervisor was shown photos of the concerns observed by the surveyor in Rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10. He stated he had been at the facility for 4 years. He stated housekeeping was responsible for cleaning the entire rooms, He stated maintenance was responsible for cleaning the air filters and he was unsure of when and how often they are cleaned. He stated there was a schedule for cleaning the resident rooms. He stated his team was responsible for cleaning the areas mentioned. He stated not cleaning the resident rooms thoroughly could not have pleasing appearance.During an interview on 02/19/26 at 12:04 p.m., the Maintenance Supervisor stated he was responsible for cleaning the air filters in the air-conditioning units. He stated the filters were cleaned quarterly. He stated he was the only one responsible for cleaning the filters and he could not get to them as frequently as he needed. He stated not cleaning the air filters could result in residents getting sick.During an interview on 02/19/26 at 12:57 p.m., the Administrator was informed of the concerns observed by the surveyor in Rooms #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10. He stated he expected housekeeping to thoroughly clean the rooms. He stated not cleaning the rooms thoroughly would not be a homelike environment and not cleaning the air conditioning filters could impact residents breathing.Record review of the facility's policy on Safe and Homelike Environment, dated 10/01/2025, revealed, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility, both inside and outside, maximizes resident independence and does not pose a safety risk.