STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	745040	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Sarah Roberts French Home	1315 Texas Ave San Antonio, TX 78201

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review the facility failed to at the time each resident is admitted , the facility must have physician orders for the resident's immediate care for 1 of 8 (2) residents in that:Resident #2 did not have an order to be admitted to the facility.This could affect all new resident admission and could delay care.The Findings were: Record review of Resident #2's admission Record dated 11/1/2025 with diagnoses of diabetes II, anxiety disorder, hypertension, acute respiratory failure with hypoxia, cognitive communication deficit, altered mental status, and urinary tract infection. Record review of Resident #2's physician orders dated 11/1/2025 at 2:27 PM revealed on I hereby certify that this resident requires/continues to require nursing facility care for 180 days. Ordered by physician. This does not say Resident #2 will be admitted to the facility. Record review of Resident #2's nurse practitioner visit dated 11/18/2025.Record review of Resident #2's psychiatry initial evaluation dated 11/12/2025.Record review of Resident #2's chart revealed no record of a physician visit. Record review of Resident #2's Quarterly MDS dated [DATE] revealed she had was admitted on [DATE], had moderately impaired vision, a BIMS of 7/13 (severe impairment), had behaviors, wandering, required mobilization of wheelchair, she required supervision for ADLs, she was frequently incontinent of bowel/bladder, she was administered injections/insulin medications, and she was receiving therapy services.Record review of Resident #2's Care Plan dated 11/2/2025 revealed she was diabetic, had surgery to head from a previous fall at home, ADL self-care, risk for wandering, resident prefers activities of choice, risk for falls related to weakness, resident has evidence of weakness, memory impairment, unable to manage medications and had difficulty falling asleep.Interview on 2/3/2026 at 12:25 PM with Resident #2 stated she had not been visited by a physician, since her admission.Interview on 2/5/2026 at 5:27 PM with LVN B stated she admitted Resident #2 from the hospital on [DATE]. LVN B stated Resident #2 did not have an order to admit to the facility. LVN B stated the software batch for new admission must not include the admission orders. LVN B stated DON was responsible for making sure the orders were reviewed.Interview on 2/5/2026 at 5:38 PM with DON stated after reviewing Resident #2s orders, she did not see orders for this resident. No comment. Record review of policy for Physician's progress notes (no date) revealed Regulation states that a resident must be seen by a physician on a specific timeline after admission. After admission, a resident must be seen within the first 30 days, then every 30 days thereafter to complete the first 90 days of the stay. After the 90-day time frame the resident must then be seen every 60 days. a. The physician does have the option to delegate these visits to the physician assistant (PA) or the nurse practitioner (NP). However, within the first 90 days after an admission the attending physician themselves must at least alternate visits with the PA or NP during Medicare admission.

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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review the facility failed to ensure residents were seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter for 1 of 8 (Resident #2) residents that required physician visits in that: Resident #2 was not seen by a physician within the first 90 days after admission. This could affect all new admissions and could result in a delay in care. The findings were:Record review of Resident #2's admission Record dated 11/1/2025 reflected with diagnoses of diabetes type II, anxiety disorder, hypertension, acute respiratory failure with hypoxia, cognitive communication deficit, altered mental status, and urinary tract infection. Record review of Resident #2's physician orders dated 11/1/2025 at 2:27 PM revealed on I hereby certify that this resident requires/continues to require nursing facility care for 180 days. Ordered by physician. This does not say Resident #2 will be admitted to the facility. Record review of Resident #2's nurse practitioner visit dated 11/18/2025 reflected. Record review of Resident #2's psychiatry initial evaluation dated 11/12/2025. Record review of Resident #2's chart revealed no record of a physician visit. Record review of Resident #2's Quarterly MDS dated [DATE] revealed she was admitted on [DATE], had moderately impaired vision, a BIMS of 7/13 (severe cognitive impairment), had behaviors, wandering, required mobilization of wheelchair, she required supervision for ADLs, she was frequently incontinent of bowel/bladder, she was administered injections/insulin medications, and she was receiving therapy services. Record review of Resident #2's Care Plan dated 11/2/2025 revealed she was diabetic, had surgery to her head from a previous fall at home, ADL self-care, risk for wandering, risk for falls related to weakness, resident has evidence of weakness, memory impairment, unable to manage medications and difficulty falling asleep. In an interview on 2/3/2026 at 12:25 PM Resident #2 stated she had not been visited by a physician, since her admission. In an interview on 2/5/2026 at 5:27 PM LVN B stated she admitted Resident #2 from the hospital on [DATE]. Record review of policy for Physician's progress notes (no date) revealed Regulation states that a resident must be seen by a physician on a specific timeline after admission. After admission, a resident must be seen within the first 30 days, then every 30 days thereafter to complete the first 90 days of the stay. After the 90-day time frame the resident must then be seen every 60 days. a. The physician does have the option to delegate these visits to the physician assistant (PA) or the nurse practitioner (NP). However, within the first 90 days after an admission the attending physician themselves must at least alternate visits with the PA or NP during Medicare admission.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents were provided pharmaceutical services (including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 8 Residents (Resident #7) reviewed for medication administration. LVN C administered a whole pill medication to Resident #7 who required her medications to be crushed. This Failure could place residents at risk for not receiving the intended therapeutic effects of their prescribed medications.The findings included: A record review of Resident #7's admission record dated 2/4/2026 revealed an admission date of 4/29/2024 with diagnoses which included Alzheimer's disease (a progressive neurodegenerative disorder and the most common cause of dementia. It affects memory, thinking, behavior, and the ability to perform daily activities), anxiety, hypertension (high blood pressure). A record review of Resident #7's quarterly MDS assessment dated [DATE] revealed Resident #7 was an [AGE] year-old female admitted for long term care related to safe assistance with activities of daily life (ADL). Resident #7 was assessed with a BIMS score of 6 out of a possible 15 which indicated severe cognitive impairment. A record review of Resident #7's care plan dated 2/4/2026 revealed, The resident has a swallowing problem related to Gerd (a chronic digestive disorder where stomach acid frequently flows back into the esophagus, irritating its lining, often causing heartburn and regurgitation, and occurs when the lower esophageal sphincter muscle weakens or relaxes abnormally) mechanical altered diet . all staff to be informed of residents special dietary and safety needs . A record review of Resident #7's imaging report dated 5/12/2025, titled Physician MBSS Consult Summary revealed, Supported in report for MBSS sic[modified barium swallow study] physician / SLP sic[speech language pathologist (a healthcare professional who diagnoses and treats communication and swallowing disorders across all ages)] and instrumental findings . Recommendations: . strategies for pills: choking risk - crush meds sic[medications] or liquid form . A record review of Resident #7's physicians orders dated 2/4/2026 revealed the physician prescribed Resident #7 was to receive pills crushed and or in liquid form, choking risk . crush meds or liquid form . A record review of Resident #7's physicians orders dated 2/4/2026 revealed on 4/23/2025, the physician prescribed Resident #7 pantoprazole 20mg, (a medication that reduces acid production in the stomach, allowing the esophagus to heal) daily in the morning. An observation on 2/4/2025 at 1:45 PM, revealed the facility's medication cart on which Resident #7's medication was stored revealed, Resident #7's pharmacy supplied medication card for pantoprazole. The card was delivered with 30 pills of pantoprazole 20mg pills and had 4 pills left. Further review revealed the pharmacist had labeled the medication with instructions do not crush. A record review of Resident #7's February 2026 medication administration record revealed Resident #7 was administered pantoprazole 20mg pill on 2/2/2026, 2/3/2026, and 2/4/2026. During an interview on 2/4/2026 at 1:35 PM LVN E demonstrated Resident #7's pantoprazole medication card as supplied by the pharmacy. LVN E stated the pantoprazole was a whole pill enteric coated and should not be crushed. LVN E stated Resident #7 had an order to crush her medications. LVN E stated the pantoprazole was scheduled to be administered at 5 am prior to her scheduled shift. During an interview on 2/4/2026 at 2:12 PM Pharmacist D stated he had access to Resident #7's medical record orders and stated Resident #7 had an order for a mechanically altered diet for mechanical crush diet texture and Resident #7 was prescribed pantoprazole delayed release medication which should not be crushed. Pharmacist D stated if the medication was crushed it would be ineffective. Pharmacist D stated the resident could receive a version of pantoprazole sprinkles which could be administered in a substance like applesauce. During an interview on 2/04/2026 at 2:44 PM LVN C stated Resident #7 was prescribed a mechanically altered diet and had her pills crushed however Resident #7 could tolerate the small (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pantoprazole pill and she had administered the pills whole without crushing. LVN C stated pantoprazole was an enteric coated pill which should not be crushed. During an interview on 2/4/2026 at 5:00 PM the Administrator and the DON stated the expectation was for nursing staff to administer medications as prescribed. The DON stated Resident #7 was assessed without negative outcomes and the physician was given a report and had issued no new orders. The Administrator and the DON stated the failure could potentially put residents at risk for not receiving the intended therapeutic effects of their medications. A record review of the facility's Medication Administration and General Guidelines policy dated March 2025, revealed, Medications are administered as prescribed, in accordance with state regulations using good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medications, . Prior to administration, the medication and dosage schedule on the residence medication administration record is compared with the medication label. If the label and the medication administration record are different and the container is not flagged, indicating a change in directions, or if there is any other reason to question the dosage or directions, the physicians' orders are checked for the correct dosage schedule. Facility personnel will contact the sic[name of the pharmacy] if any discrepancies are noted.