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	07/10/2025

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 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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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.