STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455444	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa Vista Inn Health Center	5756 N Knoll Dr San Antonio, TX 78240

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41095 Based on interview and record review, the facility failed to ensure residents had the right to be free from accidents and hazards for 1 of 4 residents (Resident #1) reviewed for accidents and hazards. On 04/09/24, Resident #1, who resided in the Memory Care wing of the facility, managed to undo the lock on the window of his room, kick out the screen and climb out the window. Resident #1 then left the property and was not located until the morning of 04/10/24. The non-compliance was identified as past noncompliance. The IJ began on 04/09/24 and ended on 04/10/24. The facility had corrected the noncompliance before the investigation began on 12/15/24. This failure could place residents at risk of harm, serious injury, or death. Findings include: Record review of Resident #1's Admission Record documented a [AGE] year-old male admitted to the facility 04/01/24 with diagnoses that included unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; major depressive disorder (mental disorder characterized by at least 2 weeks of pervasive low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities); paranoid schizophrenia (a type of psychosis where your mind doesn't agree with reality), and epilepsy (a group of non-communicable neurological disorders characterized by recurrent epileptic seizures). Record review of Resident #1's Care Plan with the admitted [DATE] documented a Focus of The resident is at risk for wandering related to disoriented to place, history of attempts to leave facility unattended (from previous), impaired safety awareness. Resident wanders aimlessly. Interventions included Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book; If the resident is exit seeking, stay with the resident and notify the charge nurse by calling out, sending another staff members, call system, etc. Record review of Resident #1's Admission MDS dated [DATE] documented a BIMS score of 3. Record review of Resident #1's Discharge MDS dated [DATE] documented a BIMS score of 11. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a timeline created by the Regional Compliance Nurse revealed that resident was last seen in the facility around 1:00 pm on 04/09/24 when he was given a Tylenol by the nurse and then he went to his room to lay down. Around 4:00 pm staff noted resident was not in his room, his bedroom window was open and the screens were torn. The staff determined that Resident #1 used the hanging rod in his closet to unscrew the window fastener on his window so that he could open and window and get out. Elopement protocols were immediately put in place and the facility and surrounding areas were searched. The family and physician were notified. The police were notified. Employees at a nearby service station confirmed they had seen Resident #1 in their parking lot but he was no longer there. The city's bus system was provided with a flyer for their drivers to watch for the resident. The search continued throughout the night. Around 8:55 am on 04/10/24, the Regional Compliance Nurse was driving toward the city's main homeless shelter when she spotted Resident #1 standing on the corner. Resident #1 agreed to get in her car and allowed her to return him to the facility. Resident #1 did not know how he got to where he was found but stated to the nurse that he was looking for work. He was taken to the facility and assessed for injuries. A skin assessment noted only two small abrasions which appeared to be scabbed over. The physician sent him to the ER for evaluation. Upon Resident #1's return to the facility later that day, he was placed in another room that overlooked the secured courtyard. Observation revealed that all of the window fasteners in the Memory Care Unit had been replaced with a device that required special tools to remove them. Record review of monitoring forms revealed Resident #1 was placed on 15-minute monitoring which remained in place until his discharge on 05/28/24. Record review of inservice training dated 4/9/24 revealed that 100% of the staff consisting of 112 employees, were inserviced on the elopement protocols. Prior to and after this incident, Elopement Drills were conducted which included staff having to find an identified individual. Inservice training was conducted on all shifts. Record review of Resident #1's Care Plan reflected it was updated on 4/10/24 with an elopement. The interventions included Q 15 minute checks x 3 days, assess/record/report to MD risk factors for potential elopement, supervise closely and make regular compliance rounds whenever resident is in room, determine the reason the resident is attempting to elope, distract resident from elopement attempts by offering pleasant diversions, structured activities, food, conversation, television, books, and if the resident is exit seeking, stay with the resident and notify the charge nurse by calling out, sending another staff member, call system, etc. Record review indicated that all residents in the Memory Care Unit were reassessed for Elopement Risk. No other residents had been noted to make attempts to elope other than going to the exit doors which alarmed when attempts were made to push them open without entering a code in the keypad. Observation of door alarms were noted to sound when pushed without first entering a code on the keypad to enter or exit the secure unit. Interviews with 12 staff members who worked either first or second shift, revealed they received training monthly on elopement protocols and participated in Elopement Drills. Staff also noted that Resident #1 was seen going to the nurses station numerous times during the day to call one of his family members to try and get her to come and get him. Staff interviewed revealed that Resident #1 frequently stayed in his room and rarely participated in activities. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the 12 staff members were conducted on 12/18/24 from 1:42 p.m. to 12/19/24 at 11:40 a.m. Staff indicated the protocol was to do a thorough sweep of the facility when they noticed a resident missing. The nurse manager would be informed and a Code Orange would be announced. Management takes over after Code Orange is announced. Staff further indicated they are constantly keeping an eye on their residents on the memory care unit by checking on them every 1 to 2 hours. Record review of Resident #1's Nurse Progress Notes in his electronic medical record, revealed that on 05/25/24, Resident #1 was involved in an altercation with another resident. Resident #1 hit Resident #2 in his eye as they were passing in the hall and fractured Resident #2's eye. The attack was unprovoked. Record review of discharge notice in the electronic medical record revealed Resident #1 was given a discharge notice on 05/28/24 with the reasons for discharge being: 1) The discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. and 2) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident. Resident #1 was sent to the hospital for altered mental status and did not return to this facility. The facility Administrator was presented with a PNC IJ template on 12/20/24 at 9:21 a.m. The facility had already completed a thorough investigation and put protocols in place to prevent a similar occurrence and had discharged the identified resident.