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	03/22/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observation, interviews, and record reviews the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse and neglect for 1 of 1 facility in that: The ADM did not follow the ANE policy and procedures by not reporting a serious injury of unknown source to HHSC when: Resident #1 fell , went to the hospital, and received 6 sutures to her forehead. This could affect all resident that had a fall and could result in further injuries. The Findings were: Record review of policy Abuse/Neglect dated 2003 reflected The resident had the right to be free of abuse, neglect misappropriation of resident property and exploitation. E: Reporting, Facility employees must report all allegations of abuse, neglect exploitation mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report the allegation to HHSC. 1. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation. B. if the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation. Record Review of Resident #1's Admission Record dated 3/18/2025 reflected she was [AGE] years old; she was admitted on [DATE] and she had Hospice services. Record Review of Resident #1 diagnoses reflected dementia (a general term for a decline in mental ability that interferes with daily life, encompassing various conditions affecting memory, thinking, and reasoning.), major depressive disorder (a common and serious mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that significantly interfere with daily life), Parkinson's disease (a progressive neurodegenerative disorder that affects the brain's ability to produce and use dopamine), joint pain, and metabolic encephalopathy (a condition where the brain's function is impaired due to a disturbance in the body's metabolism). (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Resident #1's significant change MDS dated [DATE] reflected a BIMS score of 00/15 (severely cognitively impaired), she had disorganized thinking evidenced by fluctuating and inattention. Resident #1 had verbal behaviors present 4-6 days, she had no upper/lower extremity impairment, she required substantial max assistance for toileting, upper/lower body dressing, and putting on footwear. Resident #1 was frequently incontinent, had falls, weighed 116 pounds, was on hospice services, and was receiving physical therapy services. Record Review of Resident #1's Care Plan reflected she had diagnoses of osteoarthritis, potential/actual impairment to left forehead related to fall, alteration in neurological status related metabolic encephalopathy, Parkinson's disease, delirium or an acute confusion episode related to disorganized thinking, impaired cognitive function/dementia or impaired thought processes, impaired visual function age related to macular degeneration, communication problem related to impaired ability to make self-understood and understand others, depression, potential to demonstrate physical behaviors related to poor impulse control, a risk for falls, and had potential for pain related to chronic debility. Record Review of Resident #1's incident report dated 3/15/2025 revealed she had an unwitnessed fall, she was found on the floor and had a laceration to her forehead, staff called 911 and was sent to the hospital. The facility did notify family, hospice, and physician. Record review of incident revealed in notes section, dated 3/15/2025, Resident #1 stated I just fell , she appeared to roll out of bed. Record Review of Resident #1's progress note dated 3/15/2025 at 3:30 PM revealed she hit her forehead and was sent out to the hospital, and she came back to the facility the same day, with 6 sutures. In an observation and interview on 3/18/25 at 9:35 AM, the Wound Care Nurse performed wound care to Resident #1's forehead in the secured Unit. Observation revealed a bruise to the left eye and 6 stitches on the forehead. Resident #1 was alert and oriented x1 (alert to self). Resident #1 could not answer any direct questions about the injury to her forehead and her eye. In an interview on 3/18/25 at 9:40 AM, the DON stated Resident #1 fell this weekend (3/15/2025), it was unwitnessed, and she was sent to the emergency room . The DON stated the unwitnessed fall with injury was not reported to HHSC. In an observation on 3/19/2025 at 1:22 PM with Resident #1, she was sitting at the nurses' station with a nurse. Her left eye area was bruised, and the top of her forehead had sutures. In an interview on 3/19/2025 at 1:25 PM with RN A in the secure unit, RN A stated Resident #1 fell on Saturday, went to the hospital, and had sutures. RN A stated it was unwitnessed. RN A stated Resident #1 was ambulatory and had a shuffle. RN A stated Resident #1 fell on [DATE] (Sat) and had a laceration to her forehead. On 3/15/2025, she went to the emergency room , and returned to the facility with 6 sutures to her forehead. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/19/2025 at 6:00 PM, the ADM and DON stated that Resident #1's fall was not witnessed by staff but could tell she fell forward. The ADM/DON felt it was not abuse/neglect since they knew how she fell . The ADM stated Resident #1 fell forward and no staff was around Resident #1 at the time of the fall. The ADM stated Resident #1 fell on [DATE] but she did not report the unwitnessed fall to HHSC.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observations, interviews and record reviews the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedures for 1 of 1 facility in that: Resident #1 had an unwitnessed fall, went to the emergency room , and received 6 sutures to her forehead. This was not reported by the ADM to HHSC. This deficient practice could result in the delay of investigating the residents' circumstances after sustaining a serious injury of unknown source. The findings were: Record Review of Resident #1's Admission Record dated 3/18/2025 reflected she was [AGE] years old, she was admitted on [DATE] and she had Hospice services. Record Review of Resident #1 diagnoses reflected dementia (a general term for a decline in mental ability that interferes with daily life, encompassing various conditions affecting memory, thinking, and reasoning.), major depressive disorder (a common and serious mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that significantly interfere with daily life), Parkinson's disease (a progressive neurodegenerative disorder that affects the brain's ability to produce and use dopamine), joint pain, and metabolic encephalopathy (a condition where the brain's function is impaired due to a disturbance in the body's metabolism). Record Review of Resident #1's significant change MDS dated [DATE] reflected a BIMS score of 00/15 (severely cognitively impaired), she had disorganized thinking evidenced by fluctuating and inattention. Resident #1 had verbal behaviors present 4-6 days, she had no upper/lower extremity impairment, she required substantial max assistance for toileting, upper/lower body dressing, and putting on footwear. Resident #1 was frequently incontinent, had falls, weighed 116 pounds, was on hospice services, and was receiving physical therapy services. Record Review of Resident #1's Care Plan reflected she had diagnoses of osteoarthritis, potential/actual impairment to left forehead related to fall, alteration in neurological status related metabolic encephalopathy, Parkinson's disease, delirium or an acute confusion episode related to disorganized thinking, impaired cognitive function/dementia or impaired thought processes, she had impaired visual function related to macular degeneration, communication problem related to impaired ability to make self-understood and understand others, she had depression, potential to demonstrate physical behaviors related to poor impulse control, a risk for falls, and had potential for pain related to chronic debility. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Resident #1's incident report dated 3/15/2025 revealed she had an unwitnessed fall, she was found on the floor and had a laceration to her forehead, staff called 911 and was sent to the hospital. The facility did notify family, hospice, and physician. Record review of incident revealed in notes section, dated 3/15/2025, Resident #1 stated I just fell , she appeared to roll out of bed. Record Review of Resident #1's progress note dated 3/15/2025 at 3:30 PM revealed she hit her forehead and was sent out to the hospital, and she came back to the facility the same day, with 6 sutures. In an observation and interview on 3/18/25 at 9:35 AM, the Wound Care Nurse performed wound care to Resident #1's forehead in the secured Unit. Observation revealed a bruise to the left eye and 6 stitches on the forehead. Resident #1 was alert and oriented x1(alert to self). Resident #1 could not answer any direct questions about the injury to her forehead and her eye. In an interview on 3/18/25 at 9:40 AM, the DON stated Resident #1 fell this weekend (3/15/2025), it was unwitnessed, and she was sent to the emergency room . The DON stated the unwitnessed fall with injury was not reported to HHS. In an observation on 3/19/2025 at 1:22 PM with Resident #1, she was sitting at the nurses' station with a nurse. Her left eye area was bruised, and the top of her forehead had sutures. In an interview on 3/19/2025 at 1:25 PM with RN A in the secure unit, RN A stated Resident #1 fell on Saturday, went to the hospital and had sutures. RN A stated it was unwitnessed. RN A stated Resident #1 was ambulatory and had a shuffle. RN A stated Resident #1 fell on [DATE] (Sat) and had a laceration to her forehead. On 3/15/2025, she went to the emergency room , and returned to the facility with 6 sutures to her forehead. In an interview on 3/19/2025 at 6:00 PM, the ADM and DON stated that Resident #1's fall was not witnessed by staff, but the ADM/DON could tell she fell forward. The ADM/DON felt it was not abuse/neglect since they knew how she fell . The ADM stated Resident #1 fell forward and no staff was around Resident #1 at the time of the fall. The ADM stated Resident #1 fell on [DATE] but did not report the unwitnessed fall to HHSC. Record review of policy Abuse/Neglect dated 2003 was documented The resident had the right to be free of abuse, neglect misappropriation of resident property and exploitation. E: Reporting, Facility employees must report all allegations of abuse, neglect exploitation mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report the allegation to HHSC. 1. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation. B. if the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observations, interviews and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 7 (Resident #2) residents in that: Resident #2's fall mat was not on the ground near her bed as specified in her care plan. Resident #2 had a fall and had behaviors and required a fall mat to prevent injury. This deficient practice could place residents at risk for not receiving proper care and services due to incomplete care plans. The Findings were: Record Review of Resident #2's Admission Record dated 3/17/2025 reflected she was admitted on [DATE] and readmitted on [DATE]. Resident #2's diagnoses included dementia (a general term for a decline in mental ability that interferes with daily life, encompassing various conditions affecting memory, thinking, and reasoning), repeated falls, pressure ulcer of sacral region stage 4, and seizure (sudden, temporary disruptions in brain electrical activity that can cause changes in behavior, movement, sensation, and awareness.) Record Review of Resident #2's Quarterly MDS dated [DATE] reflected her BIMS score was 15/15 (cognitively intact), she had impairments to both lower extremities, she required substantial/maximal assistance with bathing, upper/lower body dressing, and with footwear. Resident #2 had repeated falls, and osteoporosis (a condition that weakens bones, making them fragile and prone to fractures, often developing silently until a fracture occurs.) with fracture. Section in Behaviors was listed, Resident #2 had a rejection behavior exhibited 1 to 3 days . Record Review of Resident #2's Care Plan dated 1/6/2025 reflected Resident #2 had physical behaviors such as pounding on the bed with fists repeatedly, and it may be possible that she intentionally places self on the fall mats. Resident #2 had an actual fall in August 2024 and interventions were fall mats. Record review of the visitor log, showed a signature for Resident #2's family dated 3/19/2025. In an observation on 3/18/2025 at 3:48 PM with Resident #2, she was lying in bed with covers on her. Resident #2's right-side fall mat was vertical against a chair . In an interview on 3/19/2025 at 3:28 PM, the DON stated Resident #2 had a visitor and they must have moved the mat out of the way and forgot to put it back. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/20/2025 at 5:41 PM, Resident #2 stated she could not remember if she had visitors/family this week. Resident #2 stated a staff person put the mat on the side, vertical, but was not sure of the staff's name. In an interview on 3/21/2025 at 1:11 PM, Resident #2's family stated she did visit on Wednesday (3/19/2025) and she did move the mat,so she could move the chair closer to Resident #2. Resident #2's family stated she put the mat back before she left for the day. In an interview on 3/21/2025 at 11:27 AM, the SW stated Resident #2 was interviewable and alert and oriented most of the time. In an interview on 3/21/2025 at 3:16 PM, the DON stated the fall mats did not have to have orders but was in the care plan for behaviors. In an interview on 3/19/2025 at 2:33 PM with the MDS LVN B stated Resident #2's fall mats were for behaviors, throwing herself to floor. Record review of policy titled comprehensive Care Planning, with no date, reflected The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the residents' rights that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental psychosocial needs that are identified in the comprehensive assessment. Each resident will have a person-centered comprehensive care plan developed and implement to meet his other preferences and goals, and address the resident's medical, physical and mental and psychosocial needs.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26869 Based on observation, interview and record review the facility must ensure that a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 7 residents (Resident #2) reviewed for pressure sores, in that: The facility failed to ensure Resident #2's air mattress was was dialed to the correct weight. This failure could affect residents with skin injures and wounds and could place the residents at risk for worsening of pressure ulcers. The findings were: Record Review of Resident #2's Admission Record dated 3/17/2025 reflected she was admitted on [DATE] and readmitted on [DATE]. Resident #2's diagnoses included dementia (a general term for a decline in mental ability that interferes with daily life, encompassing various conditions affecting memory, thinking, and reasoning), repeated falls, pressure ulcer of sacral region (is at the bottom of the spine and lies between the fifth segment of the lumbar spine (L5) and the coccyx (tailbone).)stage 4, and seizure (sudden, temporary disruptions in brain electrical activity that can cause changes in behavior, movement, sensation, and awareness.) Record Review of Resident #2's consolidated orders for March 2025 reflected cleanse sacral stage 4 pressure ulcer with normal saline, pat dry, apply medihoney to wound bed, cover with calcium alginate, and cover with foam dressing every day or as needed if soiled, one time a day for Wound care and may have pressure air mattress every shift. Record Review of Resident #2's March 2025 MAR reflected may have pressure air mattress every shift was administered as ordered. Record Review of Resident #2's Quarterly MDS dated [DATE] reflected her BIMS score was 15/15 (cognitively intact), she had impairments to both lower extremities, she required substantial/maximal assistance with bathing, upper/lower body dressing, and with footwear. Resident #2 had a pressure ulcer of the sacral regions, stage 4, and osteoporosis (a condition that weakens bones, making them fragile and prone to fractures) with fracture. Record Review of Resident #2's Care Plan dated 1/6/2025 reflected Resident #2 had a stage 4 pressure ulcer to her Sacrum, and interventions included the resident required the use of an air mattress. Record review of Resident #2's chart revealed her weight was 114 pounds. In an observation on 3/18/2025 at 3:49 PM in Resident #2's room, the air mattress was set to over 310 pounds. In an observation on 3/18/2025 at 3:51 PM, the DON revealed Resident #2's air mattress was set to over 310 pounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/18/2025 at 3:50 PM, Resident #2 stated she was not comfortable on the air mattress. In an interview on 3/18/2025 at 3:52 PM, the DON stated Resident #2 weighed 114 pounds and she will adjust the air mattress dial to her weight. In an interview on 3/19/2025 at 2:33 PM, MDS LVN B stated Resident #2 had an air mattress for a pressure ulcer and the nurses could adjust the weight according to the resident's weight. In an interview on 3/19/2025 at 3:38 PM, the DON stated the air mattresses should be dialed at the resident's weight. The DON stated the nurses could adjust the dial on resident air mattresses and she was not aware that it was set over 310 lbs. The DON stated she had no policy.