

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2025
NAME OF PROVIDER OR SUPPLIER Mesa Vista Inn Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>(continued on next page)</p>

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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 2 of 4 residents (Resident #2 and Resident #3) reviewed for dignity. The facility failed to ensure residents' privacy/dignity was maintained during wound observations/care on (2) occasions. These failures could affect residents by contributing to poor self-esteem, decreased self-worth and quality of life. Findings included: Record review of Resident #2's admission Record, dated 10/17/25, revealed the resident was re-admitted to the facility on [DATE] with diagnoses which included: Type 1 Diabetes (condition in which the pancreas makes little/no insulin, resulting in high blood sugar) and Peripheral Vascular Disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Record review of Resident #2's quarterly MDS assessment, dated 9/30/25, revealed the resident had a BIMS score of 14, suggesting intact cognition. During observation of Resident #2's wound to the right lower leg and wound care to left heel, on 10/16/25 beginning at 4:44 pm, revealed LVN A, accompanied by ADON B, entered the room, approached Resident #2 and explained the procedure. Further observation revealed LVN A completed wound care to the left heel. Further observation revealed LVN A and ADON B did not close the door, blinds, or privacy curtain. Observation revealed Resident #2's roommate was in the room. During an interview on 10/17/25 at 1:50 pm, Resident #2 said privacy was not a thing at the facility. Resident #2 further stated sometimes the staff closed the privacy curtain during care and sometimes they did not. Resident #2 further stated not providing privacy had become the norm, adding that it would be nice if they practice privacy. Resident #2 said she felt like a bag of dried oats just plopped on the bed and forgotten. During an interview on 10/17/25 at 3:34 pm, ADON B said Resident #2 should have been asked if she preferred the curtain open or closed. ADON B further stated she did not think about asking Resident #2 about the privacy curtain because she knew that Resident #2 felt comfortable with her roommate. Record review of Resident #3's admission Record, dated 10/17/25, revealed the resident was re-admitted to the facility on [DATE] with diagnoses which included: Vascular Dementia (Brain damage caused by multiple strokes), Type 2 Diabetes (chronic condition that affects the way the body processes blood sugar), and Aphasia (disorder that affects a person's ability to communicate). Record review of Resident #3's quarterly MDS assessment, dated 9/2/25, revealed the resident's cognitive skills for daily decision making was severely impaired. During observation of Resident #3's wound to the right lower leg and wound care to the left heel, on 10/16/25 beginning at 4:16 pm, revealed LVN A, accompanied by ADON B, entered the room, approached Resident #3 and explained the procedure. Further observation revealed LVN A removed the dressing to Resident #3's lower right leg exposing the wound for assessment and completed wound care to the left heel. LVN A and ADON B did not close the blinds before resident care. During an interview on 10/17/25 at 12:48 pm, LVN A said he was expected to provide residents with total privacy by closing the door, privacy curtains, blinds, and only exposing the area to be treated. LVN A further stated it was important to respect the residents' privacy and dignity because not doing so could cause the residents embarrassment. During an interview on 10/17/25 at 3:34 pm, ADON B said she and LVN A should have knocked on Resident #3's door and closed the blinds prior to providing resident care to maintain the resident's privacy. ADON B said she thought she and LVN A must have forgotten to close the blinds in Resident #3 room, before assessing/treating her wounds, because Resident #3 was in a private room, but they closed the door. ADON B further stated not knocking or letting a resident know what was going to be done was a dignity issue. ADON B said not closing the blinds in Resident #3's room during care may have made her feel exposed. ADON B further stated privacy should be provided to residents any time resident care was provided, including when clothes were changed, in the restroom and during transfers. ADON B said it was all o the nursing management's responsibility to educate staff and ensure policies/procedures were reinforced. During an interview on 10/17/25 at 5:16 pm, the DON said privacy should always be provided to the residents. The DON further stated that privacy curtains should be pulled all the way around the bed and blinds closed during resident care because it could affect the residents' dignity. The DON said residents that could not communicate may not be able to verbalize discomfort but may also be affected and so privacy should always be provided and dignity maintained. The DON said it was the responsibility of all the nursing managers to ensure that residents' privacy/dignity was respected. Record review of a webpage titled Exercising Your Rights as a Nursing Facility Resident by the</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 5 residents (Resident #2, Resident #3, and Resident #4) reviewed for infection control. The facility failed to ensure staff wore PPE during wound care for Resident #2 who was on enhanced barrier precautions. The facility failed to ensure LVN A and ADON B appropriately doffed (removed) PPE after providing care to Resident #3 and Resident #4. This deficient practice could put residents at risk for infection. Findings included: 1. Record review of Resident #2's admission Record, dated 10/17/25, revealed the resident was re-admitted to the facility on [DATE] with diagnoses which included: Type 1 Diabetes (condition in which the pancreas makes little/no insulin, resulting in high blood sugar) and Peripheral Vascular Disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). Record review of Resident #2's Care Plan, dated 8/29/25, revealed: Resident is on enhanced barrier precautions. Gloves and gown should be donned (put on) if any of the following activities are to occur. high-contact activity. During observation of Resident #2's wound to the right lower leg, on 10/16/25 beginning at 4:44 pm, revealed LVN A, accompanied by ADON B, approached Resident #2 in her bedroom and explained the procedure. Further observation revealed LVN A removed the dressing to the left lower leg, exposing the wound for observation without donning PPE (includes, but is not limited to gown and gloves). During an interview on 10/17/25 at 12:48 pm, LVN A said he felt rushed and nervous during the observation of care to Resident #2's wound to the right lower leg on 10/16/25. LVN A further stated he honestly forgot to don PPE. LVN A said it was important to wear PPE during resident care so that it limited the spread of infection to the residents and staff. During an interview on 10/17/25 at 3:34 pm, ADON B said Resident #2 was on EBP. ADON B further stated they (LVN A and ADON B) did not wear PPE because they thought the state investigator just wanted to see the wound, adding that Resident #2's wound was not a pressure wound, and that was why she thought they did not need to wear PPE. ADON B further stated they should have worn PPE because the wound was going to be exposed. ADON B said PPE should be worn any time a resident had an open wound and/or indwelling devices. ADON B further stated EBP was to provide protection and to avoid the spread of infections. 2. Record review of Resident #4's admission Record, dated 10/17/25, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Dementia (group of thinking and social symptoms that interferes with daily functioning). Record review of Resident #4's quarterly MDS assessment, dated 9/10/25, revealed the resident's cognitive skills for daily decision making was severely impaired. During observation of wound care to Resident #4's right and left heels, on 10/17/25 beginning at 10:19 am, revealed LVN A, accompanied by ADON B, approached Resident #2 in her bedroom, explained the procedure, and completed wound care. Further observation revealed ADON B removed the glove on her left hand and continued to remove the glove on her right hand by grasping the glove, on the palm area, with her left ungloved hand. Further observation revealed LVN A removed his gloves, after which LVN A and ADON B removed their gowns by grasping the gown in the front and pulling away from the body. During an interview on 10/17/25 at 12:48 pm, LVN A said when he removed his gown he should have grabbed the gown from the back because the front was contaminated and not doing so could possibly spread infections. Record review of Resident #3's admission Record, dated 10/17/25, revealed the resident was admitted to the facility on [DATE] with diagnoses which included: Vascular Dementia (Brain damage caused by multiple strokes). During observation of wound care to Resident #3's left heel, on 10/16/25 beginning at 4:16 pm, revealed LVN A, accompanied by ADON B, approached Resident #2 in her bedroom, explained the procedure, and completed wound care. Further observation revealed ADON B removed the glove on her left hand and continued to remove the glove on her right hand by grasping the glove, on the palm area, with her left ungloved hand. During an interview on 10/17/25 at 3:34 pm, ADON B said when she removed dirty gloves, she pulled one glove and tucked her fingers of the ungloved hand inside of the other glove and pulled it off. ADON B said she thought that was how she removed her gloves after wound care for Resident #3 and Resident #4. ADON B said it was important to remove contaminated gloves as recommended to keep their hands as clean as possible and decrease the risk of contamination/infection. ADON B said when wound care was completed for Resident #4 she removed her gloves first. ADON B further stated she was not supposed</p>		