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	12/03/2025

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 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made for 1 of 4 Residents (Resident #1) whose records were reviewed for suspicious injuries. The facility failed to report an injury of unknown injury to HHSC when Resident #1 was noted with bruising to right temple and was sent out to the hospital on 9/2/25 about 11:30 PM. This deficient practice could place the residents at risk for further abuse or neglect.The findings were: Review of Resident #1's face sheet, dated 9/25/25, revealed she was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction (Stroke) and Unspecified Dementia (often indicating a decline in cognitive function without a clear underlying cause). Review of Resident #1's quarterly MDS assessment, dated 9/10/25, revealed her BIMS score was 4 out of 10 reflective of severe cognitive impairment. Further review revealed she had disorganized thinking, inattention and had hemiplegia. Review of Resident #1's Care Plan, revised 9/4/25, revealed she hadImpaired cognitive function/dementia or impaired thought processes r/t Alzheimer's-AEB taking self to bathroom, not usingcall light for assistance, ambulates by holding on to side rail on wall. Interventions included Engage the resident in simple, structured activities that avoid overly demandingtasks. Keep the resident's, routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Use task segmentation to support short term memory deficits.The resident has a communication problem r/t Alzheimer's/ Dementia. Interventions included Anticipate and meet needs. Be conscious of resident position when in groups, activities, dining room to promote proper communication with others. Ensure/provide a safe environment: Call light in reach, Adequate low glare light, Bed in lowest position and wheels locked, Avoid isolation.The resident has an ADL Self Care Performance Deficit- HX of bumping into furniture in room when reaching for items (closet/bedside table/window frame). Interventions included Bed Mobility: supervision as needed. Toileting: supervision as needed. Walking: provide supervision as needed.The resident has a bruise to right temple. Interventions included Identify potential causative factors and eliminate/resolve when possible. Monitor location, size of bruise. Report abnormalities to MD. Resident resides in the Secure Care Unit, related to diagnosis of dementia and Alzheimer's and risk for elopement. Disease Process, disoriented to place, Interventions included Admit to Secure Care unit per MD orders. Involve resident in daily activities designed for Secure Care Unit. Notify MD of any changes. Review of Radiology report dated 9/2/25 revealed the views of Resident #1's face/orbits were taken and there was no obvious fracture or destructive bony process was apparent. Impression: The plain films of the face are limited in detection of nondepressed facial and orbital features. If there is significant clinical concern for facial fracture, then CT evaluation should be obtained for better evaluation. Review of hospital report dated 9/4/25 revealed Resident #1 presented to the emergency department for evaluation of worsening hematoma (closed wound where blood collects and fills a space inside your body because it can't flow or drain out) on the right side of her head and periorbital ecchymosis (describes bruising and discoloration around a person's eyes that resemble the dark circles around a raccoon's eyes). Further review revealed Impression:Moderate right anterolateral frontal scalp contusion/hematoma without underlying calvarial fracture.Focal recent extra-axial hemorrhage along the right convexity measuring 5 mm in thickness.Very thin posterior parafalcine subdural hematoma measuring 3 mm with suspected very slight involvement of the right cerebral tentorium. Suspect of 2 mm of leftward midline shift.Mild right-sided facial and preorbital soft tissue swelling.No acute facial bone fracture.No acute cervical spine fracture or dislocation. Observation and interview on 9/23/25 at 11:35 AM revealed Resident #1 was sitting at a table in the therapy room drinking coffee. Resident #1 easily engaged in conversation and stated she was doing fine. There were no noted visible bruising on Resident #1. Interview with ST A revealed Resident #1 was on their caseload r/t cognition and they were providing swallow training. ST A stated Resident #1 needed reminders to slow down when eating and drinking fluids. Interview on 9/23/25 at 11:45 AM with PTA B revealed Resident #1 was on their caseload for balance and gait training. Interview on 9/23/25 at 11:50 AM with the ADON and DON revealed on 9/2/25 during shift change the morning nurse reported Resident #1 had bruising to her left hand and right temporal area. She stated Resident #1 was unable to state what happened but denied any pain. The ADON stated Resident #1 ambulated independently, however, her gait was unsteady and would hold on to the rail while walking down the hall. The ADON stated she reviewed Resident #1's chart and it revealed she had a blood draw on