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	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa Vista Inn Health Center	5756 North Knoll Drive 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 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** Based on interviews, and record reviews, the facility failed to develop and implement a comprehensiveperson-centered care plan for each resident, consistent with the resident rights, which includes measurable objective andtimes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in thecomprehensive assessment for 1 Resident (Resident #1) of 5 residents reviewed for comprehensive person-centered. care plans. The facility failed to ensure Resident #1's comprehensive care plan addressed the active diagnosis of osteoporosis. This deficient practice could place residents at risk of missed or miscommunicated care. Findings included: Record review of Resident #1's electronic face sheet dated 06/16/2026 reflected a [AGE] year-old female admitted on [DATE] with a diagnosis of osteoporosis (bone disease characterized by weak fragile bones). Record review of Resident #1's annual MDS assessment dated [DATE] reflected that she could rarely understand and rarely be understood. She was not a candidate for a BIMS which signified her cognitive status was severely impaired. She was dependent on staff for ADLs. She was coded to have an active diagnosis of osteoporosis. She was not inter-viewable. Record review of Resident #1's comprehensive care plan dated 06/03/2026 did not reflect her diagnosis of osteoporosis. Record review of Resident #1's Active Orders as of: 06/16/2026 reflected she was prescribed alendronate sodium (works by slowing down bone breakdown, increase bone density and lower risk of fractures) oral tablet 70 mg for osteoporosis, give one time a day every Thursday with a start date of 05/28/2025. Record review of Resident #1's MAR dated 05/1/2026 to 5/31/2026 reflected she received alendronate sodium once a week for the month of May 2026. During an interview on 06/16/2026 at 12:10 pm, the MDS nurse stated Resident #1's osteoporosis was an active diagnosis, and she was treated for it, so it needed to be on her comprehensive care plan. She stated she did not know how it was missed and an inaccurate care plan could lead to inaccurate information and care provided. She stated she was accountable for the care plans with an interdisciplinary team. During an interview on 06/16/2026 at 3:15 pm, the DON stated she was not aware that Resident #1's osteoporosis was not reflected in her care plan. She stated accurate care plans are needed for the resident's specific care required. During an interview on 06/16/2026 at 3:18 pm, the ADM stated Resident #1's comprehensive care plan needed to reflect her active diagnoses because she received that care and care could be missed or wrong if the care plan was inaccurate. Record review of the facility's policy and procedure titled Comprehensive Care Planning (undated) reflected The facility will 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.

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
	455444	A. Building B. Wing	06/16/2026

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Mesa Vista Inn Health Center	5756 North Knoll Drive San Antonio, TX 78240

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review and revise the comprehensive care plan for 1 (Residents #1) oof 5 residents reviewed for comprehensive care plans, in that: Resident #1's comprehensive care plan was not revised to reflect that she no longer took antipsychotic and antianxiety medications. This deficient practice could result in substandard level of care. Findings included: Record review of Resident #1's electronic face sheet dated 06/16/2026 reflected a [AGE] year-old female readmitted on [DATE]. Her diagnoses included: anxiety (feeling nervousness, or unease), major depressive disorder (serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities and various emotional and physical problems) and insomnia (sleep disorder). Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected she was not taking an antipsychotic or antianxiety medication. She was not a candidate for a BIMS which signified her cognitive status was severely impaired. Record review of Resident #1's annual MDS assessment dated [DATE] reflected that she could rarely understand and rarely be understood. She was not a candidate for a BIMS which signified her cognitive status was severely impaired. She was dependent on staff for ADLs. She was not coded to be taking an antianxiety or antipsychotic medication. Record review of Resident #1's Active Orders as of: 06/16/2026 reflected she was not prescribed an antipsychotic or antianxiety medication. Record review of Resident #1's comprehensive care plan dated 06/10/2025 reflected Focus, the resident requires anti-psychotic medications r/t mood/behaviors, Interventions, administer medications as ordered. Monitor/document for side effects and effectiveness. Further review reflected, Focus, the resident uses anti-anxiety medications, Interventions, give anti-anxiety medications ordered by physician. Monitor/document side effects and effectiveness. During an interview on 06/16/2026 at 12:10 pm, the MDS nurse stated Resident #1's comprehensive care plan was reviewed but not revised when she was no longer prescribed and taking antipsychotic and antianxiety medications. She stated that information was important, especially for monitoring the residents for side effects and behaviors. She stated Resident #1 had not been on an antianxiety or antipsychotic medication through 2 MDS assessment cycles. During an interview on 06/16/2026 at 3:15 pm, the DON stated she was not aware that Resident #1's care plan needed to be reviewed and revised after MDS assessments for changes in the required care. During an interview on 06/16/2026 at 3:18 pm, the ADM stated Resident #1's comprehensive care plan needed to reflect her active diagnoses because she received that care and care could be missed or wrong if the care plan was inaccurate. Record review of the facility's policy and procedure titled Comprehensive Care Planning (undated) reflected. The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.