| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455444 | A. Building<br>B. Wing | 04/24/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mesa Vista Inn Health Center | 5756 N Knoll Dr<br>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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 3 of 8 residents (Resident #2, Resident #72, and Resident #89) whose rooms were observed for personal refrigerators. The facility failed to assist in maintaining personal refrigerator logs, in fridge thermometers, and/or discarding spoiled food for Residents #2, #72, and #89. These deficient practices could place residents at risk of food-bone illnesses.The findings were: 1.Record review of Resident #2's face sheet, dated 4/24/26, revealed the resident was a [AGE] year-old female, initially admitted to the facility on [DATE], readmitted on [DATE], with diagnoses including sacral spina bifida with hydrocephalus (a congenital condition in which the spinal column does not close completely and is accompanied by excess cerebrospinal fluid accumulation in the brain), major depressive disorder, and acquired absence of left leg above knee (surgical amputation). Record review of Resident #2's admission MDS assessment, dated 4/7/26 revealed the resident's cognition was fully intact for daily decision making. Record review of Resident #2's care plan revealed the resident had a focus area of impaired cognitive function/dementia or impaired thought processes, initiated on 04/03/2026, with interventions including staff providing consistent communication, reducing environmental distractions, offering structured activities, maintaining routine, monitoring for changes in cognitive status, and providing cues for redirection and safety, and a focus area of ADL self-care performance deficit, initiated on 04/03/2026, with interventions including staff assistance with bathing, dressing, toileting, and bed mobility, use of assistive devices, staff participation with transfers, repositioning in bed, encouragement of participation in self-care to the fullest extent possible, and monitoring and reporting changes in function. During an observation on 4/24/26 at 9:17 a.m., Resident #2 had a personal refrigerator in her room, the refrigerator did not have a thermometer or a temperature log. Resident #2 stated no one from the facility ever checked her refrigerator. 2.Record review of Resident #72's admission record/face sheet revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including unspecified intracranial injury without loss of consciousness, subsequent encounter (brain injury affecting neurological function); major depressive disorder, recurrent, unspecified (mood disorder characterized by persistent sadness and impaired functioning); other chronic pain (ongoing pain affecting daily activities); lumbago with sciatica, right side (lower back pain radiating down the leg affecting mobility); age-related osteoporosis without current pathological fracture (bone loss increasing risk for fractures and impacting physical strength); osteonecrosis, unspecified (bone tissue death due to decreased blood supply affecting mobility and function); and personal history of traumatic brain injury (prior brain injury associated with potential long-term cognitive and neurological impairment). Record review of Resident #72's admission MDS assessment, dated 3/2/26 revealed the resident's cognition was fully intact for daily decision making. Record review of Resident #72's care plan revealed the resident had a focus area of impaired cognitive function/dementia or impaired thought processes, initiated on 02/26/2026, with interventions including staff providing consistent communication, (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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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | reducing environmental distractions, engaging the resident in simple structured activities, maintaining routine, monitoring and reporting changes in cognitive status, providing cues for redirection, and use of task segmentation to support memory deficits, and a focus area of ADL self-care performance deficit, initiated on 02/26/2026, related to generalized weakness and abnormal gait, with interventions including staff assistance with bathing, dressing, toileting, and bed mobility, assistance with personal hygiene, encouragement of participation in self-care, use of assistive devices, staff support with transfers, and monitoring and reporting changes in function. During an observation on 4/21/26 at 8:19 a.m., Resident #72 had a personal refrigerator in his room. The refrigerator did not contain a thermometer or a temperature log. During a follow-up observation and interview on 4/24/26 at 3:15 p.m., no thermometer was inside the personal refrigerator and no temperature log. Resident #72 stated no staff had told him he would be responsible for cleaning out his refrigerator. He stated that housekeeping had come and wiped off the top of the refrigerator. Resident #72 stated no one had mentioned anything about a thermometer to him. 3. Record review of Resident #89's admission record/face sheet, the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including unspecified dementia with agitation (a progressive cognitive disorder characterized by impaired memory, judgment, and increased behavioral disturbances such as agitation), major depressive disorder (a mental health disorder characterized by persistent feelings of sadness, loss of interest, and impaired daily functioning), anxiety disorder (a condition involving excessive worry, nervousness, and impaired concentration), insomnia (a sleep disorder characterized by difficulty initiating or maintaining sleep), metabolic encephalopathy (a condition involving altered mental status due to systemic metabolic dysfunction), paraplegia (paralysis of the lower extremities resulting in significant mobility limitations), mononeuropathy and polyneuropathy (nerve disorders causing weakness, numbness, and decreased functional ability), chronic pain (persistent pain affecting physical function and activity tolerance), and history of spinal cord injury (resulting in long-term neurological and mobility impairments). Record review of Resident #89's quarterly MDS assessment, dated 3/19/26 revealed the resident's cognition was fully intact for daily decision making. Record review of Resident #89's care plan revealed the resident had a focus area of impaired cognitive function/impaired thought processes, initiated on 02/26/2020, with interventions including staff providing consistent communication, reducing environmental distractions, maintaining routine, using simple instructions, providing cues for redirection, and monitoring and reporting changes in cognitive status, and a focus area of ADL self-care performance deficit, initiated on 05/18/2018, related to paraplegia, with interventions including staff assistance with bathing, dressing, toileting, and bed mobility, provision of sponge baths as needed, nail care and hygiene monitoring, assistance with transfers, encouragement of participation in self-care, and use of call light for assistance, and a focus area of impaired mobility related to paraplegia, with interventions including staff assistance with bed mobility, transfers, and supervision with locomotion. During an observation, interview, and record review on 4/21/26 at 8:06 a.m., Resident #89 was observed to have a personal refrigerator in his room. The refrigerator had a temperature log attached to the outside; however, the log did not indicate the month and included entries labeled 1st-15th and 16th-23rd. The freezer compartment contained ice buildup with brown discoloration noted in areas. The bottom of the refrigerator contained a towel with an unknown brown substance. A nutritional shake labeled with another resident's name, dated 1/3/26 with instructions to keep frozen, was observed in the refrigerator. Multiple food items were observed without dates. The resident stated staff and family had not assisted with cleaning out the refrigerator. During a joint interview on 4/23/26 at 11:28 a.m., the Administrator and DON stated they had champions who were assigned to each hallway. They stated the champions should be checking the residents' personal refrigerators. They stated they were unsure who the specific champion for Resident #89 was. They stated each fridge should have a thermometer and temperature log. They stated residents and their families were expected to keep the refrigerators clean themselves and supply a thermometer for the fridge. They stated if they had not been provided<br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | with a thermometer by family the facility could provide one for them. They stated Resident #89 was never roommates with the resident who was listed on the health shake he had in his fridge and Resident #89 had behaviors of not allowing staff to help him clean his fridge. They stated staff should have noticed the condition of Resident #89's fridge and assisted him with it. The facility stated they were responsible for the residents and they could get sick if they consumed spoiled items. Record review of facility policy titled Personal Refrigerators Policy, (Dietary Services Policy & Procedure Manual, FP 00-10.1), no date, revealed residents of the facility may place a personal or dormitory size refrigerator in their room if space permits and under Life Safety Code regulations. the care and maintenance of any refrigerator is the responsibility of the resident and/or responsible party. housekeeping can assist the resident and/or family member by inspecting the refrigerators at least weekly and assist with removal of outdated food items and cleanliness. the resident and/or resident representative should clean and maintain the refrigerator according to the manufacturer's user manual. the refrigerator compartment should be maintained at temperatures of 35-41 degrees. the freezer compartment should be maintained at zero degrees or less. temperatures can be monitored by the use of a thermometer designed for a refrigerator/freezer. food should be stored in the refrigerator/freezer as determined by the food item. expired food items should not be consumed and should be discarded. any food that shows signs of spoilage. should not be consumed and should be discarded. food stored in the refrigerator that is to be consumed by the resident should be according to the resident's diet ordered by the physician. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accidents and hazards as was possible for 3 of 18 residents (Resident #29, Resident #41, and Resident #52) reviewed for quality of care. 1. The facility failed to ensure Resident #41 did not have scissors stored openly on top of the nightstand. 2. The facility failed to ensure Resident #52 did not have a bottle of mouth wash in a shared room with Resident #11. 3. The facility failed to ensure Resident #29 did not have mouth wash or tiger balm in her room. These failures could place residents at risk of harm or injury and contribute to avoidable accidents and a decline in health. The findings included:1.Record review of Resident #41's admission sheet dated 02/27/2026 documented a [AGE] year-old female with diagnoses including malignant neoplasm of the nasal cavity (cancer) and epilepsy (seizure disorder).<br><br>Record review of Resident #41's MDS assessment dated [DATE] documented a BIMS score of 13 indicating intact cognition and recorded the diagnoses of cancer and epilepsy. Further review of the MDS, documented Resident #41 had impairment in functional abilities including the need for partial/moderate assistance with ADLs.<br><br>Record review of Resident #41's order summary documented an order for the seizure medication Levetiracetam. Levetiracetam was ordered as Levetiracetam 500 mg, Give 1 tablet by mouth two times a day for Seizures.<br><br>Record review of Resident #41's care plan documented The resident has Seizure Disorder, with a goal The resident will remain free from injury related to seizure activity ., and The resident has impaired visual function ., with a goal The resident will maintain optimal quality of life within limitation imposed by visual function ., and The resident has an ADL Self Care Performance Deficit ., with a goal The resident will maintain or improve current level of function .<br><br>During an interview with RN I on 4/21/26 at 7:45 AM, RN I stated Resident #41 should not have scissors sitting out in her room, because she could harm herself. RN I stated the scissors should be stored with the nurses while not in use by the resident.<br><br>During an observation on 4/21/26 at 7:29 AM, a pair of full-size scissors was observed sitting in an opened container on Resident #41's nightstand.<br><br>On 4/21/2026 between 7:30 AM and 7:35 AM, RN I was observed walking in and out of Resident #41's room. No scissors were seen in RN I's hands after exiting the resident's room.<br><br>During an interview with the DON on 4/21/2026 at 1:28 PM, the DON stated residents should not have scissors in their rooms because they were sharp objects, and they could accidentally harm themselves.<br><br>Review of the facility admission agreement dated 9/01/2025 noted in section Items Not Allowed in Resident Room Medications: (includes all Prescription and Over-the-Counter drugs ., and Note: Items labeled 'Keep out of the reach of children' should be evaluated on a case-by-case basis and stored in a manner that is not readily available to other residents. and Scissors or Knives-should be evaluated on a case-by-case basis and stored in a manner that is not readily available to other residents.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. Record review of Resident #52's admission record/face sheet revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] from an acute care hospital with diagnoses including unspecified dementia, mild, with anxiety (cognitive impairment affecting memory, reasoning, and judgment); depression (persistent mood disorder causing sadness or loss of interest); anxiety disorder (excessive worry or fear); gait and mobility abnormalities (impaired walking or movement); and history of transient ischemic attack (TIA) (temporary interruption of blood flow to the brain causing stroke-like symptoms).<br><br>Record review of Resident #52's discharge return anticipated MDS assessment, dated 4/13/26, revealed her cognition was intact for daily decision making.<br><br>Record review of Resident #52's care plan, initiated 03/06/2026 and revised 03/19/2026, revealed the resident had impaired cognitive function/dementia or impaired thought processes. The care plan further revealed goals for the resident to maintain safety and cognitive function, with interventions including consistent supervision, reducing confusion through structured routines, communicating with the resident using simple and direct instructions, monitoring for changes in cognitive status or decision-making ability, providing structured activities appropriate to the resident's abilities, and maintaining a safe environment due to cognitive impairment.<br><br>Record review of Resident #11's admission record revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] from an acute care hospital with diagnoses including vascular dementia, moderate, with mood disturbance (progressive cognitive decline affecting memory, reasoning, behavior, and judgment); depression (persistent mood disorder causing sadness or loss of interest); anxiety disorder (excessive worry or fear); insomnia (sleep disorder causing difficulty falling or staying asleep); and cerebral infarction (stroke resulting from interrupted blood flow to the brain).<br><br>Record review of Resident #11's quarterly MDS assessment, dated 4/13/26, revealed her cognition was moderately impaired for daily decision making.<br><br>Record review of Resident #11's care plan revealed the resident had the potential to demonstrate physical behaviors including anger, depression, and self-abusive behavior, evidenced by slashing her abdomen with a butter knife to relieve headache pain, with interventions including use of plastic silverware for safety. Further review revealed interventions to evaluate medication side effects, provide choices regarding care and activities, modify the environment to reduce triggers, notify the charge nurse of physically abusive behaviors, obtain psychiatric/psychogeriatric consultation as indicated, and send the resident to the emergency room for evaluation as needed. These findings indicated the facility identified the resident as being at risk for unsafe behaviors requiring environmental safety precautions and supervision.<br><br>During an observation on 4/21/26 at 8:00 a.m. Resident #52 and Resident #11 were both in their beds in their shared room. There was a bottle of mouth wash on Resident #52's nightstand. Resident #52 stated it was her mouth wash.<br><br>During an interview on 4/24/26 at 3:13 p.m. the DON stated no residents were allowed to keep mouth wash in their room because of their mental state and they may not be aware of how to use the item properly.<br><br>3. Record review of Resident #29's face sheet dated 04/24/2026 revealed a [AGE] year-old female<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | admitted to the facility on [DATE], with diagnoses of Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (experiencing a decline in cognitive abilities).<br><br>Record review of Resident #29's MDS dated [DATE] revealed a BIMS score of 5 out of 15 indicating severe cognitive impairment and had not had any information inputted regarding personal hygiene.<br><br>Record review of Resident #29's care plan provided on 04/24/2026 revealed a focus area for the following:<br><br>The resident has an ADL Self Care performance deficit, initiated on 04/02/2026, with interventions including Assist with personal hygiene as required: hair, shaving, oral care as needed, initiated on 04/02/2026.<br><br>During an observation on 04/21/2026 at 6:48 a.m., revealed Resident #29 had mouthwash and Tiger balm in their cabinet drawer both with a label stating, Keep out of reach of children.<br><br>During an observation on 04/22/2026 at 8:58 a.m., revealed Resident #29 had mouthwash and Tiger balm in their cabinet drawer both with a label stating, Keep out of reach of children.<br><br>During an interview on 04/22/2026 at 8:59 a.m., Resident #29 stated she used the tiger balm on her legs when she was sore. Resident #29 stated they had used the mouthwash previously and had always kept the tiger balm and mouthwash in their room. Resident #29 stated staff do know, and she had never been told anything about it. Resident #29 stated they had not hurt themselves with either mouth wash or tiger balm and that other than her roommate other resident had rarely gone in her room.<br><br>During an interview on 04/22/2026 at 3:14 p.m., CNA A stated Resident #29 was in the memory care unit and that they didn't think anyone could have mouth wash or medication such as tiger balm in their possession. CNA A stated Resident #29 should not have mouthwash or tiger balm because other residents wander in and out of other rooms. CNA A stated the risk to residents that had mouthwash or tiger balm in their room could be residents eating either poisoning themselves.<br><br>During an interview on 04/22/2026 at 3:36 p.m., LVN B stated residents in the memory care unit needed assistance with mouth hygiene, and they kept mouth hygiene products in a closet that was locked. LVN B stated Resident #29 resided in the memory care unit. LVN B stated residents could not have tiger balm because it could be considered medication in which a doctor's order would have been needed and the item would have been kept away from the resident. LVN B stated they had seen residents wonder in and out of other rooms. When asked what the danger would be for a resident to have mouthwash or tiger balm in their room, LVN B stated residents could put either in their mouth or residents could have an allergic reaction.<br><br>During an interview on 04/22/2026 at 4:06 p.m., the DON stated residents could not have any medications, mouthwash or any products that had a label stating out of reach for children in their rooms. When asked what the danger would be for a resident to have mouthwash or tiger balm in their room the DON stated the resident could ingest it, have an allergy or reaction to it, or other residents could wander into each other's rooms and take things. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to include procedures that assured the accurate dispensing and administering of all drugs for 3 of 7 carts (700/800 hall nurse cart, 700/800 hall medication cart, and 100/400 nurse cart) reviewed for pharmacy services. 1.The facility failed to ensure the controlled substance reconciliation logs were signed for accuracy of medication quantities during shift change. 2. The facility failed to remove expired medications (Naproxen 220mg, and 5 insulins) from the medication cart. This failure could place residents at risk of not receiving their prescribed medications, experiencing untreated pain and anxiety, and a decreased quality of life.The findings included: 1.During an observation of the 700/800 hall nurse cart on 4/23/2026 at 9:12 AM, four signatures were observed to be missing from the controlled medication reconciliation log used to audit the count of controlled substances between cart exchange. During an interview with LVN L on 4/23/2026 at 9:12 AM, LVN L stated there should not be missing signatures on the controlled medication reconciliation log. LVN L stated it was important for the log to be accurate to make sure no discrepancies exist. LVN L stated if signatures were missing from the log, medications could be missing, and residents might not get the medications they need. During an observation of the 700/800 hall medication cart on 4/23/26 at 9:22 AM, four signatures were observed missing from the controlled medication reconciliation log, and one signature was signed in advance of the next cart exchange. During an interview with LVN M on 4/23/2026 at 9:22 AM, LVN M stated there should not be missing signatures or signatures signed in advance of cart exchange on the controlled medication reconciliation log. LVN M stated the log should be signed at the time of the medication count to ensure accuracy, and staff members should be conducting the count at the same time. LVN M stated if the count of controlled medication was off, residents could be missing their medications, and their care could be delayed. During an interview with the DON on 4/23/2026 at 10:41 AM, the DON stated her expectation for the controlled medication reconciliation logs was that they should not have missing signatures or be signed in advance of the medication count. The DON stated staff should be signing the log at the time of the count to ensure the accuracy of the inventory. The DON stated if the log was inaccurate, they would need to address it, because medications could be missing or a drug diversion could occur. Review of the facility's policy titled Controlled Medications-Administration, dated 2025, noted Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations. 8. At each shift change, a physical inventory of all controlled medications is conducted by two licensed nurses and/or one nurse and a .Med Tech or equivalent as allowed by your State regulatory agency and is documented on an audit record. 2.During an observation of the 100/400 hall nurse cart on 4/23/2026 at 9:39 AM, a bottle of Naproxen 220 mg (an analgesic medication for pain relief) with a manufacturer's expiration date of 5/2025 was observed inside the cart. Further observation of the cart revealed it contained five insulins which were outside of the 28 day opened by expiration date. During an interview with LVN J on 4/23/2026 at 9:39 AM, LVN J stated that expired insulins and other medications should not be in the cart because they might not be effective or safe. During an interview with the DON on 4/23/2026 at 10:41 AM, the DON stated there should not be expired medications in the medication carts. The DON stated expired medications should not be administered to residents, because the resident might not get the full dose or full potency of the medication, and it could be less effective. The DON further stated her expectation for staff was that they check the carts every shift for expired items. Review of the facility policy titled Medication Labels dated 2025 noted Medications are labeled in accordance with facility requirements, state, and federal laws. and 1. Each prescription medication label includes: Expiration date . |

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|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interviews, and record reviews the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 warming kitchen reviewed for sanitation in that: The DA (Dietary Aide) failed to wash her hands prior to plating food.CNA A entered the warming kitchen during meal service without a hair net and did not wash her hands prior to getting ice out of the ice machine to fill a glass.There were no paper towels in the paper towel dispenser by the handwashing sink in the warming kitchen.These failures could place residents at risk for food-borne illness, and food contamination. The findings included: During an observation of meal service from the warming kitchen in the secure unit on 04/21/26 at 12:40 pm, the DA was observed plating food from the steam table without washing her hands. During meal service, she returned to the main kitchen to obtain more plates and left a second time to retrieve more bowels. The DA did not wash her hands upon returning to the warming kitchen to continue plating food from the steam table. During the same observation period while food was being served, CNA A was observed entering the warming kitchen without a hair net and did not wash her hands. She went to the ice machine to fill a glass with ice and then left the kitchen. During the observation, it was also noted there were no paper towels in the paper towel dispenser above the hand washing sink. During an observation and interview with the DM and DA on 04/21/26 at 1:14 pm, the DM brought more plates to the DA. The DM was asked if staff were allowed to come into the kitchen during meal service without a hair net and without washing their hands. The DM stated that no one should enter the area during meal service without a hair net. The DM also stated the DA as well as the CNA should have washed their hands prior to serving food or getting ice out of the machine. The surveyor pointed out the lack of paper towels in the dispenser to the DM. The DM stated that housekeeping was supposed to keep all dispensers filled and stated she would ensure the housekeeper was made aware of this need and would fill the dispenser. Record review of The Dietary Food Service Personnel Policy and Procedures dated 2012 under the section Sanitation and Food Handling listed:All employees receive instruction in sanitation during orientation and through in-service training programs.Hair nets or hats covering the hairline are worn at all times. [NAME] guards are required for facial hair.Wash your hands (with soap and hot water) before starting work, after coughing or sneezing, handling garbage, picking up an article from the floor, after handling soaps or detergents, after using the toilet, after smoking, and after all breaks. Touching something that is not clean and then handling food can cause food poisoning. |

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| | 455444 | A. Building<br>B. Wing | 04/24/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Mesa Vista Inn Health Center | 5756 N Knoll Dr<br>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) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, 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 disease and infection for 4 of 32 residents reviewed (Resident #2, Resident #39, Resident #79, and Resident #94) and 3 of 4 (LNV E, RN G and MA H) facility staff observed for infection control. 1. The facility failed to ensure LVN E maintained proper hand hygiene during wound care for Resident #2. 2. The facility failed to ensure Resident #39's indwelling urinary catheter bag was not in a trash can with a dirty brief. 3. The facility failed to ensure Resident #79's indwelling urinary catheter bag was not touching the floor. 4. The facility failed to ensure RN G wore a PPE gown while administering medication to Resident #94, who was on enhanced barrier precautions, through a PEG/G tube (a flexible feeding tube inserted through the abdominal wall into the stomach that allows for the delivery of nutrition, fluids, and medications directly into the stomach). 5. The facility failed to ensure MA H sanitized scissors before using them to open a bottle of medication during medication pass. These failures could place residents at risk for cross contamination and infection. The findings included:1. Record review of Resident #2's face sheet, dated 4/24/26, revealed the resident was a [AGE] year-old female, initially admitted to the facility on [DATE], readmitted on [DATE], with diagnoses including sacral spina bifida with hydrocephalus (a congenital condition in which the spinal column does not close completely and is accompanied by excess cerebrospinal fluid accumulation in the brain), pressure ulcer of contiguous site of back, buttock, and hip, stage 4 (full-thickness tissue loss with exposed bone, tendon, or muscle), cellulitis (bacterial skin infection), neuromuscular dysfunction of bladder (impaired bladder function caused by nerve damage), and acquired absence of left leg above knee (surgical amputation).<br><br>Record review of Resident #2's admission MDS assessment, dated 4/7/26/ revealed the resident's cognition was fully intact for daily decision making.<br><br>Record review of Resident #2's care plan, initiated 4/3/2026 and revised 4/21/2026, revealed the resident had pressure ulcers or potential for pressure ulcer development including stage 4 right sacrum (full-thickness tissue loss with exposed structures), unstageable deep tissue injury to the right first toe (persistent non-intact skin with obscured tissue damage), and stage 4 right knee pressure ulcer (full-thickness skin and tissue loss), with interventions including staff were to administer treatments as ordered and monitor for effectiveness, assess, record, and monitor wound healing at least weekly including wound measurements and wound bed status, report loose or missing dressings to the nurse, provide assistance with repositioning at least every two hours, avoid positioning the resident on pressure ulcer locations, use lifting devices and draw sheets to reduce friction, provide incontinent care and moisture barrier application, monitor for new skin breakdown, and follow physician-ordered wound care treatments for the resident's sacrum, right toe, and right knee.<br><br>During an observation on 4/24/26 at 9:51 a.m. revealed LVN E and CNA F prepared and provided wound care to Resident #2's bottom. During wound care LVN E stated he forgot the tape for the wound bandage and needed to retrieve it from the nurse wound supply cart. LVN E left the room. LVN E returned without the tape and went into the resident's restroom and began washing his hands. LVN E turned off the water faucet with his barehand. LVN E then went back to the resident's room door and opened it with his barehand. LVN E then asked another staff member (with unknown hand hygiene) to hand him the tape he forgot. LVN E then grabbed the tape with his bare hands and placed it on the bedside table with other clean supplies. LVN E then washed his hands and returned to the<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | bedside, put on new clean gloves, and used the contaminated tape to secure Resident #2's dressings to her skin. During wound care, an unknown person entered the resident's shared bathroom, to which the door was open to, LVN E stopped wound care reached over, closed the bathroom door with his gloved hand, and then went back to place tape to secure the resident's bandages.<br><br>During an interview on 4/24/26 at 10:35 a.m. LVN E stated he did not realize he touched the sink with his bare hand or the door handle and then touched the tape. LVN E stated although he had touched the tape at that point the resident's wounds were already covered by a bandage and the tape was only used to secure the bandage. LVN E stated he thought he used his foot to close the bathroom door. LVN E stated if he had used his gloved hand to close the door it would be an issue of infection control for the resident's wounds.<br><br>During an interview on 4/24/26 at 3:23 p.m. the DON stated the nurse should not touch the clean supplies if he contaminated his hands because the supplies were no longer as clean as possible to prevent infections.<br><br>Record review of facility policy, undated, titled Hand Hygiene revealed .hand hygiene continues to be the primary means of preventing the transmission of infection.hand hygiene was required .after contact with a resident's mucous membranes and body fluids or excretions.recommended techniques for washing hands with soap and water include. rubbing hands together vigorously for at least 20 seconds covering all surfaces of the hands and fingers.recommended techniques for performing hand hygiene with an ABHR include applying product. covering all surfaces of hands and fingers.gloves. are not a substitute for hand hygiene.<br><br>Record review of facility policy, undated, titled Fundamentals of Infection Control Precautions revealed .hand hygiene continues to be the primary means of preventing the transmission of infection. and staff were required to perform hand hygiene .before and after entering indwelling catheters.after contact with a resident's mucous membranes and body fluids or excretions.after handling soiled or used linens, dressings, bedpans, catheters and urinals.after removing gloves or aprons.gloves do not replace the need for hand washing.failure to change gloves between resident contacts is an infection control hazard.non-invasive resident care equipment is cleaned daily or as need between use.equipment that is visibly soiled with blood or body fluids will be cleaned immediately with an approved disinfectant.environmental surfaces (e.g., bed rails, bedside tables, carts, commodes, doorknobs, faucet handles). required adequate disinfection.<br><br>2. Record review of Resident #39's admission record revealed the resident was a [AGE] year-old male, admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including unspecified dementia with behavioral disturbance (progressive cognitive decline affecting memory, reasoning, and behavior), urinary tract infection (infection involving the urinary system), acute kidney failure (sudden decline in kidney function), benign prostatic hyperplasia without lower urinary tract symptoms (noncancerous enlargement of the prostate gland), chronic obstructive pulmonary disease (chronic inflammatory lung disease causing airflow limitation), and protein-calorie malnutrition (nutritional deficiency resulting from inadequate protein and caloric intake).<br><br>Record review of Resident #39's significant change MDS, dated [DATE], revealed the resident's cognition was severely impaired for daily decision making. The MDS also revealed he had an indwelling catheter.<br><br>Record review of Resident #39's care plan, initiated 1/30/2026 and revised 4/21/2026, revealed the (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | resident had an indwelling Foley catheter related to benign prostatic hyperplasia without lower urinary tract symptoms (noncancerous enlargement of the prostate), with cognitive impairment resulting in attempts to pull out the Foley catheter. The care plan included goals for the resident to remain free from signs and symptoms of urinary tract infection, remain free from catheter-related trauma or complications, maintain urinary drainage, and reduce agitation or behaviors toward the catheter. Interventions included staff were to position the catheter bag and tubing below bladder level and in a privacy bag, maintain the drainage bag off the floor, assess tubing for kinks, secure tubing to prevent pulling, monitor intake and output, monitor for catheter-related pain or discomfort, monitor for signs and symptoms of urinary tract infection, educate staff and the resident on catheter care and removal risks, and report abnormalities to the physician.<br><br>During an observation and interview on 4/21/26 at 5:59 a.m. revealed Resident #39 was lying in bed. Resident #39's catheter bag was inside the trashcan next to his bed. The trashcan contained a dirty brief. LVN K stated the resident had placed the catheter in the trashcan on his own. She stated there was a used brief in the trash can and that could cause cross contamination. LVN K stated she tried to educate the resident to keep the catheter in place because he tried to pull it out or empty it himself. LVN K stated she was unsure what could be done as an intervention for his catheter being in the trashcan.<br><br>3. Record review of Resident #79's admission record revealed the resident was a [AGE] year-old male, admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including vascular dementia with mood disturbance (decline in cognitive function caused by impaired blood flow to the brain accompanied by mood-related symptoms), unspecified dementia with psychotic disturbance (cognitive decline with hallucinations, delusions, or other psychotic features), presence of urogenital implants (urinary device placement), obstructive and reflux uropathy (urinary tract obstruction and backward flow of urine), benign prostatic hyperplasia with lower urinary tract symptoms (enlarged prostate causing urinary symptoms), metabolic encephalopathy (global brain dysfunction caused by systemic illness), and recurrent major depressive disorder.<br><br>Record review of Resident #79's quarterly change MDS, dated [DATE], revealed the resident's cognition was severely impaired for daily decision making. The MDS also revealed he had an indwelling catheter.<br><br>Record review of Resident #79's care plan, initiated 7/23/2021 and revised 1/18/2026, revealed the resident had a suprapubic catheter related to obstructive uropathy secondary to benign prostatic hyperplasia with lower urinary tract symptoms (urinary obstruction caused by enlarged prostate), with goals for the resident to remain free from signs and symptoms of urinary tract infection and catheter-related trauma. The care plan included interventions for staff to position the catheter bag and tubing below the level of the bladder and in a privacy bag, maintain the drainage bag off the floor each shift, check tubing for kinks, ensure tubing was anchored to the resident's leg or linens to prevent pulling, monitor intake and output, monitor for pain or discomfort, monitor for urinary tract infection signs and symptoms, provide catheter site care, and report complications or abnormalities to the physician.<br><br>During an observation and interview on 4/21/26 at 5:59 a.m. revealed Resident #79 was lying in bed. Resident #79's catheter bag was touching the floor. LVN K stated the bag should not be touching the floor because it could cause cross contamination.<br><br>During an interview on 4/23/26 at 10:37 a.m. the DON stated residents' catheter bags should not be<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | touching the floor. The DON stated a basin could be used to put the catheter bag in to keep it from resting on the floor. The DON stated Resident #79 liked to place his catheter bag in the trashcan. The DON stated he had returned from the hospital recently from pulling out his catheter. The DON stated they tried to use a basin but Resident #39 would just throw it. The DON stated a catheter touching the floor or a dirty brief could be an infection control issue and the basin would have helped the catheter from getting contaminated.<br><br>Record review of facility policy, undated, titled Catheter Care, Nursing Policy and Procedure, revealed .to keep the catheter and tubing free of kinks. Keep tubing off floor.be sure the catheter tubing and drainage bag are kept off the floor. during catheter care.<br><br>4. Record review of Resident #94's admission sheet dated 4/17/2020 documented a [AGE] year-old female resident with diagnoses including psychosis, insomnia, depression, dementia, anxiety, hypercholesterolemia (elevated levels of cholesterol in the blood), and hypertension (high blood pressure).<br><br>Record review of Resident #94's MDS assessment dated [DATE] revealed a BIMS could not be conducted due to the resident rarely or never being understood and recorded the use of a feeding tube in Section K – Swallowing/Nutritional Status K0520 Nutritional Approaches.<br><br>Record review of Resident #94's order summary revealed an active order for CLEAN PEG SITE AND CHANGE PEG TUBE DRESSING/REPLACE PEG SYRINGE Q NIGHT SHIFT every night shift with an order date of 3/14/2025 and no end date.<br><br>Record review of Resident #94's care plan with an initiation date of 4/03/2024 revealed Resident is on enhanced barrier precautions ., with interventions including Gloves and gown should be donned if any of the following activities are to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity.<br><br>During an observation of g-tube medication administration on 4/22/2026 at 9:20 AM, RN G was observed wearing gloves while administering medications through Resident #94's g-tube. RN G did not wear a protective gown while administering the medications. A sign regarding information for EBP was observed posted outside Resident #94's door.<br><br>During an interview with RN G on 4/22/26 at 9:26 AM, RN G stated he should have also worn a gown when administering Resident #94's medications through the g tube since the resident was on EBP. RN G stated if a gown was not worn, it could cause the resident to get an infection.<br><br>During an interview with the DON on 4/22/26 at 3:14 PM, the DON stated for the peg tube, RN G should have worn a gown, and that proper use of PPE was important because Resident #94 was at risk of infection because the peg tube was an internal device placing the resident at risk of exposure to outside organisms like bacteria.<br><br>Review of the facility policy titled Enhanced Barrier Precautions, dated 4/01/2024, noted EBP are indicated for residents with any of the following: Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO, and Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 5. During an observation of MA H on 4/22/26 at 9:30 AM, revealed MA H took a pair of scissors out of an opened bag sitting on top of a medication cart and used them to open the foil on a new bottle of Lactulose solution. MA H did not sanitize the scissors before using them to open the foil.<br><br>During an interview with MA H on 4/22/26 at 9:45 AM, MA H stated she should have sanitized the scissors before using them to open the foil, because the scissors could cause an infection if they were not sanitized before use.<br><br>During an interview with the DON on 4/22/26 at 3:14 PM, the DON stated MA H should have sanitized the scissors before using them to open the medication bottle. The DON stated it was important to sanitize the scissors before using them to keep the medication as clean as possible and not to expose it to contamination and infection.<br><br>Review of the facility policy titled Fundamentals of Infection Control Precautions, undated, noted Resident care equipment and articles 3. Non-invasive resident care equipment is cleaned daily or as need between use . |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**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 dignity and respect in a manner and environment that enhances their quality of life for 1 of 6 residents (Resident #64) reviewed for dignity. Resident #64's catheter bag was not placed in a privacy bag and was visible from the hallway. This failure could place residents at risk for diminished quality of life, loss of dignity and self-worth.The findings included: Record review of Resident #64's admission sheet dated 4/17/2026 documented a [AGE] year-old male resident with diagnoses including type 2 diabetes mellitus, obstructive and reflux uropathy (blockage or reflux of urine leading to kidney damage), hyperlipidemia (high cholesterol), dementia, and liver cirrhosis (scarring of the liver tissue). Record review of Resident #64's MDS assessment dated [DATE], revealed a BIMS score was not recorded and documented in section C0700 the resident's memory was OK, and the resident was Independent on making decisions regarding tasks of daily life. Further review of the MDS recorded the resident's use of an indwelling catheter. Record review of Resident #64's order summary included an active order to provide Foley catheter care every shift with an order date of 3/31/2026. Record review of Resident #64's care plan with an initiation date of 4/02/2026 documented the resident has indwelling Catheter with interventions including Position catheter bag and tubing below the level of the bladder and in a privacy bag. During an observation on 4/21/2026 at 7:36 AM, Resident #64 was seen in his room with his catheter bag located on the side of the bed facing the hallway. The catheter bag was not inside a privacy bag. During a second observation on 4/21/2026 at 10:35 AM, the door to Resident #64's room was open and his catheter bag was not in a privacy bag and was visible from the hallway. During an interview with the ADON on 4/21/2026 at 10:38 AM, the ADON stated Resident #64's catheter bag should not be visible from the hallway, and it should be in a privacy bag for the resident's dignity. During an interview with the DON on 4/42/26 at 1:28 PM, the DON stated Resident #64's catheter bag should not be visible from the hallway and should be covered with a privacy bag to preserve the resident's dignity. Record review of the facility policy titled Residents Rights, undated, noted The resident has a right to personal privacy and confidentiality of his or her personal and medical records. 1. Personal privacy includes accommodations, medical treatment . |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to respect the residents' right to confidentiality in his or her personal and medical records for 1 (Resident #2) of 13 residents reviewed for dignity. The facility failed to ensure Resident #2's shared bathroom door remained closed during wound care. This failure could cause a decrease in feelings of self-worth by being exposed during care. Findings included: Record review of Resident #2's face sheet, dated 4/24/26, revealed the resident was a [AGE] year-old female, initially admitted to the facility on [DATE], readmitted on [DATE], with diagnoses including sacral spina bifida with hydrocephalus (a congenital condition in which the spinal column does not close completely and is accompanied by excess cerebrospinal fluid accumulation in the brain), pressure ulcer of contiguous site of back, buttock, and hip, stage 4 (full-thickness tissue loss with exposed bone, tendon, or muscle), cellulitis (bacterial skin infection), neuromuscular dysfunction of bladder (impaired bladder function caused by nerve damage), and acquired absence of left leg above knee (surgical amputation). Record review of Resident #2's admission MDS assessment, dated 4/7/26/ revealed the resident's cognition was fully intact for daily decision making. Record review of Resident #2's care plan, initiated 4/3/2026 and revised 4/21/2026, revealed the resident had pressure ulcers or potential for pressure ulcer development including stage 4 right sacrum (full-thickness tissue loss with exposed structures), unstageable deep tissue injury to the right first toe (persistent non-intact skin with obscured tissue damage), and stage 4 right knee pressure ulcer (full-thickness skin and tissue loss), with interventions including staff were to administer treatments as ordered and monitor for effectiveness, assess, record, and monitor wound healing at least weekly including wound measurements and wound bed status, report loose or missing dressings to the nurse, provide assistance with repositioning at least every two hours, avoid positioning the resident on pressure ulcer locations, use lifting devices and draw sheets to reduce friction, provide incontinent care and moisture barrier application, monitor for new skin breakdown, and follow physician-ordered wound care treatments for the resident's sacrum, right toe, and right knee. During an observation on 4/24/26 at 9:51 a.m. LVN E and CNA F prepared and provided wound care to Resident #2's bottom. Resident #2 was lying in the bed with her back facing the bathroom door area in her room. The bathroom door was open from 9:51 a.m. till 10:17 a.m. when an unknown person entered the shared bathroom. LVN E reached over and closed the bathroom door. During an interview on 4/24/26 at 10:35 a.m. LVN E stated Resident #2's bathroom door should have been closed during the wound care. LVN E stated he did not know it was a shared bathroom. He stated the door should be closed to provide privacy and dignity for the resident. During an interview on 4/24/26 at 3:23 p.m. the DON stated the bathroom door should have been closed during wound care to provide privacy for the resident. Record review of facility policy titled Resident Rights, policy, no date, revealed .the resident has a right to a dignified existence.a facility must treat each resident with respect and 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.personal privacy includes accommodations, medical treatment. personal care.the facility must respect the resident's right to personal privacy, including the right to privacy in his or her oral, written, and electronic communications.the resident has a right to be treated with respect and dignity. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 2 of 33 residents (Residents #88 and #113) reviewed for assessments: Resident #88's Quarterly MDS dated [DATE] did not indicate she was receiving hospice services. Resident #113's Quarterly MDS dated [DATE] did not indicate she was receiving hospice services. These failures could place residents at risk for inadequate care due to inaccurate assessments.Findings included:<br><br>Record review of Resident #88's admission Record dated 04/24/26 documented a [AGE] year-old female originally admitted to the facility on [DATE] and the last admission on [DATE]. The diagnoses included Alzheimer's disease (a progressive irreversible neurodegenerative disorder and the most common cause of dementia, characterized by memory loss, cognitive decline, and behavioral changes), unspecified severe protein calorie malnutrition (a critical medical condition indicating extreme muscle wasting, fat loss, or starvation), bipolar disorder, current episode mixed, moderate (a complex state where symptoms of both mania/hypomania and depression occur simultaneously, and unspecified anxiety disorder (diagnosis for symptoms of anxiety that cause significant distress or impairment, but do not meet the full criteria for specific disorders like Generalized Anxiety Disorder).Record review of Resident #88's last Quarterly MDS assessment dated [DATE] in Section O item K1 did not have hospice checked to indicate that these services were being delivered while she was a resident.<br><br>Record review of Resident #88's care plan with the last revision date of 11/13/25 had a focus stating The resident has a terminal prognosis and/or is receiving hospice services. DX: Alzheimer's Disease. One of the goals included was The resident's comfort will be maintained through the review date. One of the interventions listed was If receiving hospice services, work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met.<br><br>Interview with the MDS D on 04/24/26 at 11:25 am, revealed a failure to check hospice on the Resident #88's Quarterly Assessment. MDS D stated this section should have been checked to indicate she was receiving hospice services to ensure accuracy.<br><br>2.Record review of Resident #113's face sheet dated 04/21/2026 revealed a [AGE] year-old female readmitted to the facility on [DATE], with an original admission date of 10/15/2025, with diagnoses that include unspecified dementia, unspecified severity, with other behavioral disturbances (cognitive decline), acute respiratory failure with hypoxia (the lungs fail to deliver sufficient oxygen to the blood) and alcoholic cirrhosis of liver with ascites (scarring of the liver due to long-term excessive alcohol consumption).<br><br>Record review of Resident #113's MDS dated [DATE] revealed that a BIMS score could not be obtained but that the resident was severely impaired. Further review of the MDS under Section O – Special Treatments, Procedures, and Programs revealed the assessment did not include hospice care in the section O0110. Special Treatments, Procedures, and Programs in the box next to K1 Hospice care.<br><br>Record review of Resident #113's care plan provided on 04/21/2026 revealed a focus area for the following:<br>(continued on next page) |

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| | 455444 | A. Building<br>B. Wing | 04/24/2026 |

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

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident requires hospice as evidenced by terminal illness, DX: End stage liver disease initiated on 01/27/2026.<br><br>Record review of Resident #113's order summary dated 4/21/2026 revealed and order stating Admit to . hospice. with an order date of 01/27/2026.<br><br>Record review of Resident #113's medical record revealed a document titled Facility Notification which stated the resident admitted to hospice on 01/27/2026.<br><br>During an interview on 04/24/2026 at 9:22 a.m., MDS D revealed they failed to check hospice on the quarterly MDS assessment. MDS D confirmed Resident #113 was currently on hospice and that it should have been checked off to indicate the care the resident is receiving regarding nursing services. MDS D stated they followed the RAI manual.<br><br>Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1, dated October 2025, noted in Section O – Special Treatments, Procedures, and Programs Steps for Assessment 1. Review the resident's medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the assessment period defined for each column and Coding Instructions for Column b. While a Resident Check all treatments, procedures, and programs that the resident received or performed after admission/entry or reentry to the facility and within the last 14 days. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR) Level 1 residents with mental illness were provided with a PASRR Level II assessment accurately 1 of 6 residents (Resident #6) whose records were reviewed for PASRR services. The facility failed to conduct a Level 1 PASRR screening for Resident #6 after a diagnosis of PTSD and coordinate with the Local Authority to conduct a Level 2 PASRR evaluation to determine the need for specialized services. This deficient practice could place residents at risk of a diminished quality of life related to not receiving or benefiting from specialized PASRR services to meet their needs.The findings included: Record review of Resident #6's admission sheet dated 9/12/2025 with an original admission date of 3/01/2024 documented an [AGE] year-old male resident with a diagnosis of PTSD on admission [DATE]). Record review of Resident #6's MDS assessment dated [DATE] documented a BIMS score of 7 indicating moderate cognitive impairment and included a diagnosis of PTSD in Section I - Active Diagnoses Active Diagnoses in the last 7 days I6100. Post Traumatic Stress Disorder (PTSD). Record review of Resident #6's order summary included an active order for the anticonvulsant medication Depakote with an order date of 02/07/2025. Depakote was ordered as Depakote 125 mg, Give 2 capsule by mouth two times a day for mood. Record review of Resident #6's care plan with an initiation date of 4/21/2026 documented The resident has a history of trauma that may have a negative impact. The trauma is PTSD, with a interventions including: Identify situation/event/images that trigger recollections of the traumatic event and limit the resident's exposure to these as much as possible. These triggers could include: loud noises, overstimulation, sudden approaches from behind. Monitor for escalating anxiety, depression for suicidal thought and report immediately to the nurse. Monitor for escalating anxiety, depression, sleep disturbance, substance abuse, or suicidal thoughts and report immediately to the physician and to the mental health provider is applicable. Record review of Resident #6's PASRR screening dated 02/20/2024 revealed no answer was recorded in Section C PASRR Screening C0100. Mental Illness Is there evidence or an indicator this is an individual that has a Mental Illness? During an interview with MDS LVN D on 4/23/2026 at 4:40 PM, MDS LVN D stated it was important for the PASRR assessments to be accurate, because a resident could lose out on a potential service if they qualify for it. During a second interview with MDS LVN D on 4/24/2026 at 10:23 AM, MDS LVN D stated a PASRR Level 1 screening should have been done after Resident #6's diagnosis of PTSD and that it was important for the local authority to come evaluate the resident in case any interventions needed to be put into place like extra support should the resident qualify for services. During a third interview with MDS LVN D on 4/24/2026 at 12:29 PM, MDS LVN D stated they do not have a facility policy for PASRR services, and they follow the HHSC website. During an interview with the DON on 4/24/2026 at 12:52 PM, the DON stated her expectation for PASRR was for everyone to be educated appropriately on the PASRR process and the guidelines for conducting the assessments. The DON further stated it was important to know the PASRR status of a resident to provide the appropriate services they might need. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality of care for 1 of 6 residents (Resident #128) whose medical records were reviewed for accuracy, in that: The facility failed to develop a baseline care plan within 48 hours of Resident #128's admission to the facility. This failure could place residents at risk of not receiving needed care and treatment.The findings included: Record review of Resident #128's admission sheet dated 4/17/2026 documented a [AGE] year-old male resident with diagnoses including encephalopathy (a group of conditions that cause brain dysfunction), type 2 diabetes mellitus, cognitive communication deficit, disorientation (a state of mental confusion where a person is unsure about time, place, identity, or situation), hyperlipidemia (high cholesterol), alcoholic cirrhosis of the liver (scarring of the liver tissue due to long term alcohol use), and dementia. Record review of Resident #128's MDS assessment dated [DATE] documented a BIMS score of 14 indicating intact cognition and recorded the diagnoses of dementia, diabetes mellitus, hyperlipidemia, encephalopathy, alcoholic cirrhosis of the liver, cognitive communication deficit, and disorientation. Record review of Resident #128's Baseline Care Plan Acknowledgement form noted a copy of the baseline care plan was provided to the resident and the resident representative on 4/17/2026, however a baseline care plan was not included in the resident's medical record until 4/21/2026. During an interview with Resident #128 on 4/21/26 at 10:28 AM, Resident #128 stated the facility gave me a plan of care, but they took it back, because I could not read it without reading glasses. During an interview with Resident #128's Family Contact on 4/21/26 at 11:00 AM, the Family Contact stated she did not receive a baseline care plan and lived out of state. Resident #128's Family Contact further stated she had not spoken with the resident or seen a picture of him in years. During an interview with the DON on 4/23/2026 at 10:55 AM, the DON stated she would find out if the baseline care plan was the first care plan on file in a resident's medical record, or if it was located in a different place in the medical record. During a second interview with the DON on 4/23/2026 at 3:08 PM, the DON stated the CNAs look to the Kardex to determine the type of care a resident requires, and the Kardex was developed from the care plan. The DON stated if the care plan was not available, the CNAs could ask a nurse about a resident's level of care. The DON further stated a lot of the time they gave the baseline care plan verbally if the resident's responsible party was not present. During an interview with the Administrator on 4/23/2026 at 5:20 PM, the Administrator stated, Resident #128 did not get a baseline care plan until 4/21/2026 and it was a clinical records error. The Administrator stated they based the resident's care on the report from the hospital and the orders. The Administrator further stated the care plan should have been in the system before 4/21/2026, but they identified the omission and added it to the medical record. Record review of the facility's policy titled Base Line Care Plans, undated, noted Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admissions; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan. Thus facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan will-Be developed within 48 hours of a resident's admission. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice for 1 of 1 resident (Resident #5) reviewed for quality of care. The facility failed to ensure Resident #5's sterile water was dated on the oxygen concentrator. This failure could place residents at risk for infection. The findings include: Record review of Resident #5's face sheet, dated 04/21/2026, revealed a [AGE] year-old female readmitted to the facility on [DATE], with an original admission date of 01/02/2023, with a primary diagnosis of aftercare following joint replacement surgery and chronic obstructive pulmonary disease, unspecified (progressive lung disease that makes it difficult to breathe) Record review of Resident #5's MDS assessment, dated 03/14/2026, revealed that a BIMS could not be obtained, but the resident's cognition was severely impaired. Record review of Resident #5's care plan provided on 04/21/2026 revealed a focus area for the following: The resident has COPD initiated on 01/02/2023, with interventions including Give oxygen therapy when ordered and as ordered by the physician initiated on 01/02/2023. Record review of Resident #5's order summary dated 04/21/2026 revealed the following order: May administer oxygen 2-4L via NC for hypoxia O2 less than 88% as needed with an order date of 05/26/2025. During an observation on 04/21/2026 at 10:55 a.m., Resident #5's oxygen concentrator had a sterile water container attached to it with no date. During an observation on 04/22/2026 at 9:47 a.m., Resident #5's oxygen concentrator had a sterile water container attached to it with no date. During an interview on 04/22/2026 at 3:14 p.m., CNA A stated they weren't aware that Resident #5 had an oxygen concentrator. CNA A stated they weren't sure if the sterile water needed to be dated or not. During an interview on 04/22/2026 at 3:36 p.m., LVN B stated residents who used oxygen concentrators, with sterile water containers, should have the sterile water dated to signify when it was put on the oxygen concentrator. LVN B stated she wasn't aware if Resident #5 was on oxygen. LVN B stated the purpose of it was to know when the sterile water was changed and if there was no date, the risk could be the resident not getting enough moisture or the resident could get a dry nose. LVN B stated the nurse was responsible for dating the sterile water. During an interview on 04/22/2026 at 4:06 p.m., the DON stated they would need to check the policy to confirm if sterile water should have been dated. The DON stated they knew in the past they dated the sterile water, but weren't sure of the exact policy. The DON stated sterile water was dated to know how long it could be in the room and if not, the risk could be it expiring or it being exposed to mildew or bacteria. The DON stated the nurse that replaced the sterile water would be the one to date it. Record review of the facility's policy titled 2.0 Nasal Cannula, with a revision date of 06/01/2006 revealed: 16.If using a non-disposable humidifier, change bottle every seven days and change water every 24 hours to prevent bacterial contamination. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice for 1 of 1 resident (Resident #9) reviewed for quality of care: The facility did not maintain communication, coordination, or collaboration with the dialysis facility for Resident #9. This failure could affect residents who received dialysis treatments and place them at risk of complications and not receiving proper care and treatment to meet their needs. The findings included: Record review of Resident #9's care plan, dated 4/22/26, revealed a [AGE] year-old female, admitted on [DATE], with diagnosis with diagnoses including end stage renal disease (a permanent kidney condition in which the kidneys have lost nearly all ability to function, requiring renal replacement therapy such as dialysis), anemia, unspecified (a condition characterized by a decreased number of red blood cells or hemoglobin, commonly associated with chronic kidney disease due to decreased erythropoietin production), and unspecified protein-calorie malnutrition (a state of inadequate nutritional intake which may occur in residents with chronic illness, including those receiving dialysis due to dietary restrictions and increased metabolic demands). The care plan further revealed the resident had a focus area of need for hemodialysis related to end stage renal disease, initiated on 5/25/24, with interventions including staff not drawing blood or taking blood pressure in the arm with graft, encouraging the resident to attend scheduled dialysis appointments, monitoring for dry skin and applying lotion as needed, monitoring labs and reporting to the physician as needed, monitoring for peripheral edema, monitoring and reporting signs and symptoms of depression and obtaining a mental health consult if needed, monitoring and reporting signs and symptoms of infection at the access site including redness, swelling, warmth, or drainage, monitoring and reporting signs and symptoms of renal insufficiency, monitoring and reporting signs and symptoms including bleeding, hemorrhage, bacteremia, and septic shock, obtaining vital signs and weight per protocol and reporting significant changes, and working with the resident to relieve discomfort related to side effects of the disease and treatment, and indicated the resident receives dialysis every Tuesday, Thursday, and Saturday, with a goal that the resident will have no signs or symptoms of complications from dialysis through the review date. Record review of Resident #9's physician orders/April 2026 Medication Administration Report, revealed an active order for Dialysis - Date: every Tuesday, Thursday, and Saturday. Time: chair time 11 a.m., pick up 10 a.m. Address: [dialysis center]. Transport: facility transport (Tuesday and Thursday), [dialysis center] (Saturday). Bring with: dialysis binder and lunch. one time a day every Tue, Thu, Sat related to end stage renal disease, and an additional order for Weight from Dialysis center one time a day every Tue, Thu, Sat for weight. Record review of Resident #9's dialysis communication forms, from dates 3/4/26-4/23/26 revealed:3/4/26 - pre-dialysis section not signed by nurse, dialysis documentation completed, post-dialysis section blank3/7/26 - pre-dialysis section completed, dialysis documentation completed, post-dialysis section signed but not completed3/10/26 - no form and no nursing note3/12/26 - no form and no nursing note3/14/26 - pre-dialysis section completed, dialysis documentation completed, post-dialysis section completed3/17/26 - resident refused dialysis per nursing note3/19/26 - nursing note present regarding a fall, no dialysis forms present3/21/26 - pre-dialysis section completed, dialysis documentation completed, post-dialysis section not completed3/24/26 - no form and no nursing note3/26/26 - pre-dialysis section completed but not signed by nurse, dialysis documentation completed, post-dialysis section blank3/28/26 - pre-dialysis section completed, dialysis documentation completed, post-dialysis section not signed by nurse3/31/26 - no form and no nursing note4/4/26 - resident initially refused dialysis then attended, post-dialysis section not completed4/7/26 - pre-dialysis section completed but not signed by nurse, no dialysis documentation, no post-dialysis documentation4/9/26 - pre-dialysis section completed, dialysis documentation completed, post-dialysis section blank4/11/26 - post-dialysis documentation<br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | missing4/14/26 - post-dialysis documentation missing4/16/26 - pre-dialysis section completed, dialysis documentation completed, post-dialysis section blank4/18/26 - post-dialysis documentation missing4/21/26 - no dialysis documentation form found4/23/26 - no dialysis documentation form found Record review of Resident #9's weight records, documentation revealed the following: 3/5/26 at 5:03 PM - 94.2 lbs, post-treatment weight from dialysis center3/7/26 at 7:54 PM - 98.2 lbs, chair or sitting scale3/10/26 at 5:01 PM - 93.2 lbs, post-treatment weight from dialysis center3/12/26 at 4:07 PM - 93.2 lbs, post-treatment weight from dialysis center3/14/26 at 8:41 PM - 87.2 lbs, post-treatment weight from dialysis center3/17/26 at 7:14 PM - 93.2 lbs, post-treatment weight from dialysis center3/19/26 at 4:46 PM - 93.2 lbs, post-treatment weight from dialysis center3/21/26 at 6:45 PM - 97.4 lbs, chair or sitting scale3/24/26 at 4:36 PM - 97.6 lbs, post-treatment weight from dialysis center3/26/26 at 6:30 PM - 97.68 lbs, post-treatment weight from dialysis center3/28/26 at 7:51 PM - 97.4 lbs, chair or sitting scale3/31/26 at 8:18 PM - 98.3 lbs, post-treatment weight from dialysis center4/4/26 at 9:59 PM - 95.24 lbs, post-treatment weight from dialysis center4/7/26 at 9:24 PM - 95.4 lbs, post-treatment weight from dialysis center4/8/26 at 8:40 AM - 98.3 lbs, chair or sitting scale4/9/26 at 4:42 PM - 97.0 lbs, post-treatment weight from dialysis center4/11/26 at 9:14 PM - 97.7 lbs, chair or sitting scale4/14/26 at 5:36 PM - 97.2 lbs, post-treatment weight from dialysis center4/16/26 at 5:19 PM - 97.3 lbs, post-treatment weight from dialysis center4/18/26 at 6:07 PM - 97.9 lbs, chair or sitting scale4/21/26 at 6:36 PM - 95.0 lbs, post-treatment weight from dialysis center4/23/26 at 9:26 PM - 94.4 lbs, post-treatment weight from dialysis center No facility weights were found for 3/3/26, 3/12/26, and 3/24/26. During an interview on 4/22/26 at 11:05 a.m., Resident #9 stated the nurses at the nursing facility did not check her fistula and reported she checked it herself to ensure it was vibrating. During an interview on 4/24/26 at 2:37 p.m. RN I stated she was the nurse responsible for Resident #9 on 4/21/26 and 4/23/26 and she had not checked the resident's dialysis binder to ensure she filled out the pre assessment form prior to the resident leaving for dialysis. She stated she forgot to look at it. RN I stated the form needed to be filled out by the nursing facility staff in the pre assessment area and post assessment area so they and the dialysis center could compare information and note any changes in the resident's condition. RN I stated there was a breakdown in communication between the nursing facility and dialysis facility when the form was not completed and they could miss a change in the resident's condition. During an interview on 4/24/26 at 3:31 p.m. the DON stated she expected staff to fill out pre and post assessments on the dialysis communication forms. The DON stated she had not checked the forms were being completed before or delegated it to anyone yet because they were still figuring out their processes. The DON stated not completing the forms completely or accurately could cause inaccurate information and miscommunication. The DON stated for post dialysis they could miss a change in the resident's condition. Record review of the facility's policy, undated, titled Dialysis, Nursing Policy & Procedure Manual 2013, revised November 2013, revealed .Dialysis is a process used to remove fluid and waste products from the body when the kidneys are unable to do so.the purposes of dialysis are to maintain the life and well-being of the patient. and to remove unwanted substances from the blood.the facility will establish baseline information from the dialysis center. monitor changes from the baseline.the resident will receive education to access device care and restrictions.the site will be assessed for bleeding, bruising, lack of pulsations. every shift. the nurse will palpate the access. a thrill. should be felt. auscultate the access. a bruit. should be heard. conduct this procedure every shift. record the results of the examination.the facility will monitor departures and returns from the dialysis center. document the resident's vital signs, general appearance, orientation.the date and time that the resident leaves the facility. and returns. will be recorded.strict intake and output will be maintained. daily weights will be maintained. fluid restrictions will be monitored.if the resident refuses dialysis treatment, document exactly what the resident verbalizes. notify the attending physician and the dialysis center. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional principles for 1 of 7 medication carts (100/400 hall nurse cart) reviewed for medication storage and labeling. The facility failed to ensure all insulins located inside the 100/400 hall nurse cart were properly labeled with opened dates. This failure could place residents who receive medications at risk for not receiving the intended therapeutic effects of their prescribed medications.The findings included: During an observation of the 100/400 hall nurse cart on 4/23/2026 at 9:39 AM, revealed it contained two insulins which had no opened date. During an interview with LVN J on 4/23/2026 at 9:39 AM, LVN J stated it was important to have the opened date on the insulins so it is known when they will expire, because if expired medications were given to residents, it would be unknown what the effect could be. During an interview with the DON on 4/23/2026 at 10:41 AM, the DON stated her expectation for staff was that they check the carts every shift for expired items. Review of the facility policy titled Medication Labels dated 2025 noted Medications are labeled in accordance with facility requirements, state, and federal laws. and 1. Each prescription medication label includes: Expiration date . |

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| Mesa Vista Inn Health Center | 5756 N Knoll Dr<br>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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 4 residents (Resident #82) reviewed for accuracy of records: The facility failed to ensure Resident #82's hospice binder was accurate with their DNR status. These failures could affect residents whose records were maintained by the facility and could place the residents at risk of errors in care and treatment.The findings include: Record review of Resident #82's face sheet, dated [DATE], revealed a [AGE] year-old male readmitted to the facility on [DATE], with an original admission date of [DATE], with a primary diagnosis of Alzheimer's disease, unspecified (progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior). Record review of Resident #82's MDS assessment, dated [DATE], revealed the resident's BIMS score was a 3 out of 15 which indicated the resident's cognition was severely impaired. Record review of Resident #82's care plan provided on [DATE] revealed a focus area for the following: Resident has an order for Do Not Resuscitate (DNR), initiated on [DATE], with interventions including in absences of b/p, pulse, respiration, CPR will not be initiated initiated on [DATE]. Record review of Resident #82's order summary dated [DATE] revealed the following order: DNR with a start date [DATE]. Record review of Resident #82's medical record revealed a DNR document for Resident #82, signed by Resident #82's responsible party on [DATE] and signed by a physician on [DATE]. Record Review of Resident #82's hospice binder revealed the binder included a page which labeled Resident #82 as a full code. During an interview on [DATE] at 3:33 p.m., the Hospice TM stated Resident #82 was DNR and that they had previously sent a representative to the facility with the DNR documents to be placed in Resident #5's hospice binder. The Hospice TM stated the hospice binder should be accurate and have the resident's appropriate directive status. During an interview on [DATE] at 3:51 p.m., LVN B stated Resident #82 was a DNR and was on hospice services. LVN B stated the hospice binder should have the DNR in it and it should be accurate because that would make the decision to resuscitate or not. LVN B confirmed Resident #82's hospice binder reflected Resident #82 was a full code. LVN B stated they checked the binder daily for the resident's care and for any changes. During an interview on [DATE] at 3:58 p.m., the DON stated that residents' hospice binders should be up to date and accurate, so everyone was on the same page regarding the residents' care. The DON stated staff would clarify the code status with the resident's electronic record if unsure. The DON stated they believed there was no risk to the residents because the nurse would take extra measures. The DON stated there was no policy regarding hospice binders. During an interview on [DATE] at 12:38 p.m., the Administrator stated there was no policy regarding clinical records. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455444 | A. Building<br>B. Wing | 04/24/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mesa Vista Inn Health Center | 5756 N Knoll Dr<br>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 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>Based on observations, interview and record review the facility failed to post the nurse staffing data on a daily basis at the beginning of each shift for 1 (4/21/26) of 4 days reviewed in that: The daily posted nurse staffing data was not posted in the facility on 4/21/26. This deficient practice could affect all residents and could result in residents and visitors being unaware of staffing levels in the facility.Findings include: Observation on 4/21/26 at 6:42 AM of the Facility Staffing Disclosure posting on a bulletin board near the front entry revealed the clear case was empty. No staffing information was posted. In an interview on 4/21/26 at 6:42 AM the BOM stated the clear case was where they normally posted the nurse staffing hours. The BOM stated she could let this surveyor know once one was posted. Interview on 4/24/26 at 3:36 PM the DON stated it was her responsibility to post the nurse staffing hours daily. She stated there should always be something in the case even if it was from the previous day. The DON stated it was important for anyone entering he building to see what the staff ratio was daily. Record review of a facility document titled Mandatory Posting, no date, revealed Daily Staffing by shift of Licensed and Unlicensed Nursing Staff was on the list. |