

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455450	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024
NAME OF PROVIDER OR SUPPLIER Meridian Care Monte Vista		STREET ADDRESS, CITY, STATE, ZIP CODE 616 W Russell Pl San Antonio, TX 78212	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511</p> <p>Based on observation, interview and record review the facility failed to ensure that all alleged violations involving abuse or neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation result in serious bodily injury for 1 of 4 Residents (Resident #3) whose records were reviewed for abuse and neglect., in that;</p> <p>The facility failed to report to the state reporting agency (HHSC) an injury of unknown origin when Resident #3 suffered a fracture to her left tibia (lower leg).</p> <p>This deficient practice could affect any resident and could contribute to further abuse and neglect.</p> <p>The findings were:</p> <p>Record review of Resident #3's face sheet dated [DATE] revealed an admitted [DATE] and a readmitted [DATE] with diagnoses which included: moderate intellectual disabilities, autistic disorder, and unspecified fracture of upper end of tibia, initial encounter for closed fracture (break in one of the bones of the lower leg) ([DATE]).</p> <p>Record review of Resident #3's Care Plan last reviewed/ revised on [DATE] revealed the resident had a communication problem related to neurological symptoms, cognitive function, intellectual disability, autistic disorder with impaired thought processes, developmental delay, difficulty making decisions, impaired decision making and long-term memory loss and was able to voice some needs. Interventions included: Resident #3 needed staff to anticipate, meet her needs, and assist with all decision making. The care plan indicated Resident #3 said the word yes mainly.</p> <p>Record review of Resident #3's MDS assessment dated [DATE] revealed a BIMS score of 0 which indicated a severe cognitive impairment. The assessment revealed the resident had unclear speech, could sometimes make herself understood, and could sometimes understand others. The MDS assessment revealed Resident #3 required maximum assistance to total dependence with ADL care, was not able to ambulate and had total dependence on staff for transfers.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #3's x-ray results (obtained by facility in facility) dated [DATE] revealed: an acute to early subacute transverse fracture of the left proximal tibial shaft with diffuse osteopenia. (New to approximately 1 month old fracture to upper part of one of the bones in the lower left leg with demineralization of the bones which can result in bones that are brittle and break easily).</p> <p>Record review of Resident #3's hospital records dated [DATE] revealed Resident #3 was a wheelchair and bedbound resident who resided in a LTC facility and presented to the hospital via EMS with a left proximal tibia fracture. The report revealed per outside x-ray done on [DATE] which revealed acute to early subacute transverse fracture of the proximal tibial shaft. Patient intellectually impaired due to birth defects (and) cannot give history. Resident admitted and treated for left tibia fracture .</p> <p>Record review of TULIP on [DATE] revealed the facility had not self-reported Resident #3's fracture to the left tibia.</p> <p>During an observation/interview of Resident #3 on [DATE] at 1:58 p.m. at a local hospital revealed the resident was awake and alert in a hospital bed watching cartoons on the television. Resident #3 had obvious facial, hand and foot abnormalities typical of someone with a chromosomal defect. She was pleasant with a childlike demeanor. Resident #3 answered yes/no questions with unknown accuracy. Resident #3 was able to give inconsistent word responses at times to simple questions. She was not able to state how she obtained the injury to her left leg. She was not able to answer the question of where she was or why she was there. She was not able to give detailed interview questions due to her cognitive status and additional details were unable to be elicited.</p> <p>During an interview on [DATE] at 2:08 p.m., an RN at a local hospital stated Resident #3 had a chromosomal abnormality and was intellectually disabled. She stated the resident had arrived at the facility with a left leg brace and x-rays confirmed she had a fracture to the left tibia. The RN stated the facility had stated Resident #3 had broken her left leg by bumping it while getting in the facility van on an unknown date. She stated Resident #3 was not able to say what had happened to her due to her intellectual disability. She stated Resident #3 had not stated anything that could be understood other than crying for her momma. She stated Resident #3 had spinal stenosis and functional paraplegia and it was possible she was unable to feel when she was initially injured although she could feel pain when her leg was moved.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 7:39 p.m., LVN C stated he worked as a charge nurse, treatment nurse and ADON. He stated on Monday ([DATE]) around 5:00 p.m., he was told by the DON that Resident #3 had a bruise to her left leg. He stated the DON asked him to assess Resident #3 because he does skin assessments and because he was the wound care nurse. He stated when he assessed Resident #3, he noticed she had edema (swelling) to her leg at baseline (typical for the resident). He stated there was slight redness that was warm to touch and painful and he noticed a big bruise to her left leg. LVN C stated the bruise was the whole shin area approximately 12 inches long and wrapped around the back of the left calf into the soft tissue. He stated the darkest part of the bruise was on the front. LVN C stated Resident #3 only complained of pain when he touched the front of the shin and not the calf. He stated when he moved the left leg the resident moaned and complained of pain by making facial grimaces and then verbally stated it hurt. LVN C stated he notified Resident #3's physician about the bruises and the redness and warmth, and he sent the physician a picture. LVN C stated the physician responded by ordering an x-ray. LVN C stated he had performed a skin assessment on Resident #3 on Friday prior ([DATE]) and she did not have any injuries. LVN C stated it was late, so he reported to the oncoming nurse that they were getting x-rays and he left for the day. LVN C stated the DON had mentioned Resident #3 had hit her leg on the bus. He stated he did not witness the injury. He stated Resident #3 goes to Adult Day Care, M-W-F. He stated he did not know what sort of transportation she used to get the ADC. LVN C stated he had completed a whole head-to-toe assessment of Resident #3 on [DATE] and did not find any other injuries other than the left leg. He stated he was not working when the x-ray results came in.</p> <p>During an interview on [DATE] at 1:34 pm, LVN D stated on [DATE] at 6:00 am she noticed an old looking bruise with some redness to Resident #3's left lower leg. She stated she told LVN C about it and documented it in the medical record. LVN D stated Resident #3 made a face when they moved her but did not complain of pain. She stated the bruise was approximately 2 x 4 inches to the left shin. LVN D stated she asked Resident #3 what happened, and she did not say anything. She stated she did not think too much about the bruise because it was on the shin, and it looked like a typical bruise. She stated none of the CNA staff had reported any incidents or injuries. She stated no one else had documented the bruise and that was why she reported it. She stated she went off duty and when she came back to work two days later learned that Resident #3 had a fracture.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 3:45 pm, the DON stated they were not sure how Resident #3 got the fracture to her left leg. The DON stated Resident #3 went to Adult Day Care on Monday, Wednesday, and Friday by local disability public bus services. She stated a family member (who was now deceased) had really pushed for the resident to go and ride the bus. She stated that family member had set up the services which pre-dated her time at the facility as the DON. The DON stated Resident #3 traveled on the public bus without staff in attendance. She stated it was adult-to-adult hand off at each location. The DON stated on Monday [DATE], Resident #3 told the Director of Rehabilitation that she hit her leg on the bus and the Director of Rehabilitation told her (DON). The DON stated during morning meeting they read the nurses notes that documented a bruise. She stated the resident's physician was on his way to the facility so wrote it on her list to have it addressed by the physician. She stated when the physician came to the building Resident #3 was at Adult Day Care. The DON stated she told the ADON (LVN C) to do an assessment of the resident when she returned from Adult Day Care and let her know what he found. The DON stated the ADON (LVN C) informed her that he had assessed the resident and had communicated with the physician who had ordered an x-ray. She stated on [DATE] at 5:50 am the x-ray results hit her phone and she immediately notified the physician of a left tibial fracture. The DON stated the physician had Resident #3 admitted to the hospital for an orthopedic consult. The DON stated she came back to the facility after treatment at the hospital with a brace to her leg and orders for follow up in .d+[DATE] weeks. The DON stated they were treating Resident #3 for a left tibial fracture of unknown origin but according to Resident #3 she hit her leg on the bus. The DON stated Resident #3's BIMS score was 0 which indicated the resident was severely cognitively impaired. She stated she did not believe the assessment was accurate because the resident could have a conversation if she wanted to. The DON stated just because the resident did not answer questions did not mean she did not understand. The DON stated she (DON) understood questions presented to her (DON) about how she could be certain Resident #3 understood conversation given Resident #3 had documented intellectual disabilities along with chromosomal abnormalities, but she (DON) had no response to the question. The DON stated when there was an injury of unknown origin the facility looks for possible reasons for it, talks to staff, looks for possible sources and does an investigation. She stated an investigation was done. The DON stated the facility did talk about reporting the incident to HHSC but did not report it. She stated they did not report it because Resident #3 was able to give a reliable statement to the Director of Rehabilitation on what happened to her. The DON stated they still did not know how it occurred, just that it occurred on the bus. The DON stated it seemed logical to her that because Resident #3's custom wheelchair was big and not easily moveable that maybe her leg got pinched between the wheelchair and the bus although she had no evidence to prove it, it just seemed logical.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 4:45 pm, the Director of Rehabilitation stated one of her assistants was working with Resident #3 and called her over because she was grimacing on Friday [DATE]. She stated she looked at both legs and they were swollen from the thigh down which was common for this resident. She stated she noted the left leg was more swollen than the right, so she told her assistant to stop working with her on that day and let her rest. She stated there was no bruising of any kind to the left leg. The Director of Rehabilitation stated on Monday, [DATE] during morning meeting they reviewed that a bruise was noted to her left leg. She stated when Resident #3 came to rehab, she noted the resident bruising and redness to the left shin and a slight indentation. She stated no therapy was performed on her lower extremities and she talked to the DON. She stated she found out they were going to do an x-ray that day of her left leg. The Director of Rehabilitation stated she asked Resident #3 what happened. She stated Resident #3 responded the bus but that was all she told her. The Director of Rehabilitation stated sometimes Resident #3 would talk and sometimes she would not. She stated she would not say anything other than the bus. The Director of Rehabilitation stated they took Resident #3 back to her room and laid her down in bed. She stated she then reported it to Resident #3's charge nurse, whom she could not remember her name, just that it was a female. She stated the nurse responded appropriately and stated she would look at her leg. She stated she did not report it to the DON but knew the DON knew about it because she it was discussed during morning meeting.</p> <p>During an interview on [DATE] at 5:20 p.m., Resident #3's family member stated on [DATE], when Resident #3 got back from Adult Day Care it was reported to the family member that the resident had a bruise on her leg (unknown which leg) and that the facility was going to take x-rays. The family member stated the next day he learned she had a fractured leg. He stated he did not understand how it happened. He stated the facility reported they did not know how it happened, just that she was going to the hospital. The family member stated he called the Administrator and asked her how it happened, and she did not know but she was going to investigate and call the bus company. He stated nobody knows what happened. The family member stated he did not get a report of any falls. He stated he thought she might have had a fall in [DATE] but could not remember. He stated Resident #3 could not move on her own and could not just fall out of bed. He stated he felt frustrated about what was happening at the nursing home and their lack of answers.</p> <p>During an interview on [DATE] at 5:53 p.m., the Administrator stated LVN D reported Resident #3 had a bruise, and she (Administrator) mentioned it in morning meeting. Then the Director of Rehabilitation mentioned in the morning meeting that Resident #3 had pain during rehab and she told the nurse. She stated the bruise was noted on [DATE] and a nurse got an order from x-rays, and they proceeded from there. The Administrator stated they did not report the injury to HHSC (State Reporting Agency) because Resident #3 told them it happened on the bus. The Administrator stated Resident #3 had not told them how the injury occurred, just that it happened on the bus. The Administrator stated the time frame for reporting abuse or serious injury was 2 hours. The Administrator stated the facility abuse policy indicated they should report suspected abuse and neglect but, in this case, she did not suspect abuse, so she did not report.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a facility policy, titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property (undated) revealed: g. Injuries of Unknown Origin: An injury should be classified as an injury of unknown source when both of the following conditions are met i. The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident ii. The injury is suspicious because of the extent of the injury or the locations of the injury .F. Reporting and Response: The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source .are reported immediately, but not later than 2 hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury .to the administrator of the facility and to other officials (including to the State Survey Agency .)in accordance with State law through established procedures.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511</p> <p>Based on interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 6 residents (Resident #3) reviewed for care plans, in that</p> <p>The facility failed to ensure Resident #3's comprehensive care plan included:</p> <ul style="list-style-type: none"> -LIDDA representative name/office and contact information and next scheduled IDT meeting -Adult Day Care Services three days a week including the name of the facility and the name and phone number of their contact person at the ADC and interventions for continuity of care between the two facilities. -Community bus (rideshare) information to the ADC including schedule, interventions/preparation for transport, who to contact to schedule or cancel transportation and contact information. <p>These deficient practices could affect residents who required specific care, services and interventions by placing them at risk of not receiving necessary care and services.</p> <p>The findings included:</p> <p>Record review of Resident #3's face sheet dated [DATE] revealed an admitted [DATE] and a readmitted [DATE] with diagnoses which included: moderate intellectual disabilities, autistic disorder, and type 2 diabetes mellitus with diabetic polyneuropathy (diabetes with nerve damage to multiple locations).</p> <p>Record review of Resident #3's MDS assessment dated [DATE] revealed a BIMS score of 0 which indicated a severe cognitive impairment. The assessment revealed the resident had unclear speech, could sometimes make herself understood, and could sometimes understand others.</p> <p>Record review of Resident #3's Care Plan last reviewed/ revised on [DATE] revealed the resident was PASRR positive and had started Adult Day Care on Monday/Wednesday/Friday from ,d+[DATE] (9 am - 1 pm) with interventions which included: PASRR Habilitation Coordination, provide service coordination with a representative from the LIDDA and report any need to evaluate for rehabilitative services or DME to maintain current level of function but did not include the name and contact information for the LIDDA representative. The care plan indicated: invite LIDDA representative to quarterly meetings but did not indicate when the next quarterly meeting was scheduled. The care plan did not include the name of the Adult Day Care or its location. It did not include the name and phone number of the contact person at the Adult Day Care or how the facility was ensuring continuity of care between the two facilities. The care plan did not include transportation information to and from the adult day care or interventions required for transportation.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 1:04 p.m., RN B stated Resident #3 had a chromosomal abnormality. He stated she went to Adult Day Care all day on Monday, Wednesday, and Fridays. He stated she left the facility at 8:30 am via public disability transportation services. He stated they got her up, get her dressed, put her public transportation name tag on her and push her to the door (front door near reception desk). He stated when the bus arrived, they take her out of the door and the bus driver takes her and puts her on the truck (bus). RN B stated when she comes back from Adult Day Care, they do all of that in reverse. He stated facility staff did not travel with her. He stated as far as he knew the Adult Day Care did not communicate with the facility daily, or in any written form but if they had any concerns the Adult Day Care would call the DON or Administrator.</p> <p>During an interview on [DATE] at 12:46 pm, the Receptionist stated when Resident #3's bus arrived at the facility he would let the nurses know. He stated the bus was a public transportation bus that was approximately half the size of a regular bus that fit 5 regular wheelchairs. The receptionist stated that sometimes the bus driver will ask him to adjust the leg rests on Resident #3's wheelchair because the bus lift will not close with her leg rests in their normal position. He stated they had to adjust the leg rests for her to get in the bus. The Receptionist stated he cannot touch the residents, so he tells a nurse and they come and adjust them.</p> <p>During an interview on [DATE] at 1:45 pm LVN A stated Resident #3's care plan did not have a plan of care for adult day care for coordination of care, contact information, public transportation to and from the adult day care and contact information. LVN A said the care plan did not have the date of next IDT meeting or name/contact information for the LIDDA. LVN A stated the charge nurses did not update or create care plans. LVN A stated the MDS Coordinator was responsible for all care plans.</p> <p>During an interview on [DATE] at 1:55 pm the DON stated the MDS Coordinator was not in the facility and was not available for interviews as told to her by the Administrator.</p> <p>During an interview on [DATE] at 2:00 pm the DON stated there was no simple answer as to whom was responsible for comprehensive care plans. She stated it was primarily the function of the MDS Coordinator, however the department heads and facility management should edit. She stated this included the ADON, herself and the Administrator. The DON stated care plan revision was not an assigned duty of the charge nurses. The DON stated Resident #3's Adult Day Care information and transportation via public transportation disability services was not part of the care plan because there were better places for staff to look up that information such as a calendar. She stated the care plan for Adult Day Care and public transportation to and from the Adult Day care should have been care planned when the activity was initiated. She stated that occurred before she was the DON at the facility. She stated it was important in case someone wanted to look it up. The DON stated Resident #3's care plan did not include the name and contact information or next scheduled IDT meeting. The DON stated it was not her expectation for staff to review the resident's care plan to provide care for the residents. She stated the staff knew the residents and care was discussed daily. The DON stated she did not communicate with the Adult Day Care Center.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 2:21 pm, the Administrator stated Resident #3's family member (who is now deceased) was a strong advocate for Resident #3 going to Adult Day Care. The Administrator stated the family member set up and arranged the public disability transportation services. The Administrator stated she (Administrator) was responsible for scheduling. She stated she called the transportation service one week in advance to schedule the weekly bus transportation. The Administrator stated if the bus driver needed assistance they would come and ask for help as they are not allowed to touch the resident. She stated the facility staff move Resident #3's footrests so she will fit on the lift for transport. She stated the facility communicated with the Adult Day Care center through the LIDDA because they are the ones who set up the Day Care Services originally.</p> <p>During an interview on [DATE] at 4:46 p.m., the LIDDA for PASRR services (associated with AACOG) revealed Resident #3 was PASRR positive and received monthly habilitation coordination and adult day habilitation (Adult Day Care). She stated Resident #3 was getting those services through PASRR. She stated she visited Resident #3 monthly and visited the facility quarterly for care plan review. The LIDDA stated Resident #3 used a local bus service for persons with disabilities (ride share van service) to and from the Adult Day Care center. The LIDDA stated the Adult Day Care center owner calls her for any concerns or problems at the facility and she communicates the concerns to the NF, mostly through communication with the MDS Coordinator.</p> <p>Record review of a facility policy, titled Care Plans, Comprehensive Person-Centered last revised [DATE] revealed: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 7. The comprehensive, person-centered care plan a. includes measurable objectives and timeframes b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: 2. Any specialized services to be provided as a result of PASRR recommendations and 3. Which professional services are responsible for each element of care.</p>		