STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455450	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Care Monte Vista	616 W Russell Pl San Antonio, TX 78212

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to promote and facilitate resident's self determination with support of resident choice and the right to refuse care for 1 of 4 (Resident #7) reviewed for resident rights. Resident #7 was unable to refuse care without the threat of calling his family member. This failure could affect the resident's psychosocial well-being and the ability to maintain highest level of independence. The findings included: Record review of Resident #7's face sheet dated 6/19/2025 revealed a [AGE] year-old male was admitted to the facility on [DATE] with the diagnoses: hypertension, chronic kidney disease, and coronary artery disease(narrowing or blockage of the artery leading to the heart). Record review of Resident #7's Quarterly MDS dated [DATE] revealed he had a BIMS score of 15 indicative of cognition intact. Record review of Resident #7's Care Plan dated 6/13/2025 revealed he was care planned per family member's request to be called with episodes of refusal of car with changing his clothing, obsessive-compulsive. Interview on 6/19/2025 at 10:55AM Resident #7 said when he was told that his family member would be called because he refused to change his clothes, he made him feel sad and like he was not an adult. He said he did not refuse; he hesitated and then agreed to change his clothes. He said he felt like he was being threatened when they (staff) said they would call his family member when his family member was younger than him. Resident #7 said it made him feel sad because he did not want his family member to be mad at him and then he would not come to see him. He said he liked when his family member would come see him and he did not want him to be mad at him. (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

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	455450	A. Building B. Wing	06/20/2025

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/19/2025 at 2:40PM the DON said with Resident #7, it was an issue with him not wanting to change his clothes and staff would tell him they would call his family member and staff had gotten used to telling him they would call his family member as a way to get him to do things. She said it was used as a threat and she said they had to be redirected not to say that to the resident. The DON said residents should not be threatened to do things because it was a violation of their rights to make choices and it could cause psycho-social harm to the resident. Interview on 6/19/2025 at 4:40PM the Administrator said Resident #7's family member told them to call him and to inform Resident #7 that he would be called if he would refuse to change his clothes or refuse incontinent care. The Administrator said he told him they could not do that because he had the right to refuse and if he insisted, he, Resident #7's family member would be called in to the state because that would be considered abuse. The Administrator said threatening residents to comply with care was a violation of their rights and it could cause mental harm to the resident and diminish their desire to maintain their independence. Interview on 6/20/2025 at 10:05AM CNA B said he told Resident #7 that he would help him change his clothes because he was wet. When he refused, he told him that the AD would call his family member. Review of facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 2001 stated in part: Residents had the right to be free from abuse; Policy Interpretation and Implementation stated in part: 1. Protect residents from abuse by anyone but not limited to: facility staff, family members, legal representatives. 5. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to protect the rights of residents to be free from misappropriation of property for 2 of 8 residents (Resident #5, Resident #6) reviewed for misappropriation of medication. The facility failed to ensure Resident #5's and Resident #6's medications were secured and not diverted when delivered to the facility. The noncompliance was identified as past noncompliance. The noncompliance began on [DATE] and ended on [DATE]. This failure could place residents who receive pain medications at risk of diminished quality of life and distress. The findings included: Record review of Resident #5's face sheet dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses: epilepsy, hypertension, joint derangement (a chronic condition that is a result of an underlying injury), and stiff man syndrome (autoimmune neurological disorder with muscle stiffness and painful spasms). He expired on [DATE] at the facility. Record review of Resident #5's CP dated [DATE] revealed he was care planned for pain medication and epilepsy. Record review of Resident #5's QMDS dated [DATE] revealed he had a BIMS score of 14, indicative of mild cognitive deficit. Record review of Resident #5's electronic medication administration record for the month of February 2025 revealed he received the pain medication as needed, administered by LVN A. Record review of Resident #5's physician orders dated [DATE] with an end date [DATE] revealed he had orders for Norco 10mg-325mg 1 tablet by mouth every 4 hours as needed for pain. Record review of Resident #6's face sheet dated [DATE] revealed an [AGE] year-old male was admitted on [DATE] with the diagnoses: type 2 diabetes, encephalopathy (any disease or disorder that affects the brain's function or structure), quadriplegia (loss of function of all four limbs), and chronic kidney disease. Record review of Resident #6's CP dated [DATE] revealed he was care planned for hospice with diagnosis of failure to thrive, diabetes, pain due to osteoarthritis and arteriosclerosis, and chronic wounds. Record review of Resident #6's QMDS dated [DATE] revealed he had a BIMS score of 4, indicative of severe cognitive deficit. (continued on next page)

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	455450	A. Building B. Wing	06/20/2025

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's physician orders revealed he had an order dated [DATE] for Norco 10mg-325mg to give 1 tablet by mouth every Tuesday and Thursday on day shift for pain. Record review of Resident #6's eMAR for the month of February 2025 revealed the Norco was signed and administered only by LVN A. Interview on [DATE] at 3:20PM the DON said the medication diversion occurred because the Residents #5 and #6 received Norco scheduled and as needed, but Resident #5 hardly ever took the medication. She said Resident #6 was on hospice and his medication was ordered through their pharmacy. She said the reason it took so long for it to be discovered that LVN A was diverting medication was since Resident #5 rarely took his scheduled or his as needed pain medication, she would be the only person that would call in refills and the only person that received them from pharmacy. She called in refills for Resident #6's as needed Norco. She said an audit was done with the in-house pharmacy and the hospice pharmacy and they noticed there were several cards of Norco unaccounted for. The nurse was suspended and tested and was negative for Norco but positive for cocaine and she never returned to the facility. The DON said her license was referred to the BON. The DON said the process instituted was for the DON and the ADON to be notified by email when narcotics came in from pharmacy and they retrieved the invoice from the basket on the wall on the unit and checked the carts to ensure the medication was on the carts. She said an electronic signature was also done to keep track of who received the medications. She said the police were called as well. She said the residents involved in the diversion did not miss any medications because the medications were in the locked drawer, and they did not miss any if needed. She only called in refills and diverted them when delivered. Interview on [DATE] at 4:40PM with the Administrator and DON, the DON said when medications would come in from pharmacy, she would receive an email. The Administrator said the DON and ADON would get the invoice that came with the medication and check for narcotics and then check the medication carts for the quantity and dosage medications. Interview on [DATE] at 4:50PM LVN B said when narcotics come in from pharmacy, before the delivery person left, the medication had to be verified with the amount of medication, the dosage, and the resident's name. Before the medication was placed in the cart, 2 nurses had to verify the medication and with 2 signatures. Interview on [DATE] at 4:55PM LVN C (agency) said when pharmacy delivered narcotics she would verify the amount of pills, the dosage, the resident name, the medication. The medication had to be verified by another nurse for 2 signatures and then placed in the lockbox on the medication cart. Interview on [DATE] at 9:46AM LVN D (agency) said when pharmacy delivered narcotics, she would first check to make sure all the medications were accounted for (quantity of narcotic) according to the invoice before she signed to receive the medication from the driver; then she would check the medication dosage, order, and resident name with another nurse, both sign and if needed, make a narcotic count sheet and place the medication in the lockbox on the medication cart. Observation on [DATE] at 12:10PM LVN E and LVN F did narcotic count on the 1st floor, with LVN F calling the name of the medication, resident's name, and the amount remaining in the bubble card. LVN E checked the cards as he called them and the count was correct, no missing medications. (continued on next page)

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	455450	A. Building B. Wing	06/20/2025

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on [DATE] at 12:15PM LVN D (agency) and LVN G did narcotic count on the 2nd floor following the same process- calling the name and the remaining amount, while the agency nurse checked the card, no missing medications. Interview on [DATE] at 12:26PM the DON said the PNC-drug diversion was identified on [DATE] and the nurse was suspended on [DATE] because they knew it was LVN A due to pharmacy audits. She was drug tested, tested positive for cocaine and she never returned and was ultimately terminated. The PNC was corrected on [DATE] and a full facility reconciliation for the narcotics was completed, without any missing medications. The DON said in-services were done immediately on abuse, neglect, and misappropriation of property, process of receiving medication from pharmacy, and narcotic count. Record review of the in-service dated [DATE] titled Abuse, Neglect, Exploitation and Misappropriation and Preventionrevealed 81 out of 81 employees were in-serviced, including 3 out of 3 agency nurses. Record review of the in-services dated [DATE] titled Process of Receiving Medications from Pharmacy revealed 24 out of 24 nurses were in-serviced and 3 out of 3 agency nurses were in-serviced for the process. Record review of facility policy dated [DATE] titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program stated Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Record review of facility policy dated [DATE] titled Accepting Delivery of Medications stated 1.All staff follow a consistent procedure in accepting medications. 2. Any errors noted in receiving medications are brought to the attention of the pharmacist and director of nursing services. Under Policy Interpretation and Implementation stated: 2. Before signing to accept the delivery, the nurse reconciles the medications in the package with the delivery ticket/order receipt. 4. A nurse signs the delivery ticket, indicating review and acceptance of the delivery, and keeps a copy of the delivery ticket. Both the receiving nurse and the delivery agent must sign any notations about errors. 5. The delivery ticket is archived in a designated location.

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	455450	A. Building B. Wing	06/20/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 4 of 10 residents (Residents #1, #2, #3, #4) reviewed for the allegation of abuse, neglect, exploitation and or mistreatment. 1. On 12/3/2024 the facility failed to report to the state agency an allegation of abuse and or mistreatment when Resident #1's Representative alleged a nurse treated Resident #1 poorly and made Resident #1 cry. 2. On 12/23/2024 the facility failed to report to the state agency an allegation of neglect and or mistreatment when Resident #2 alleged a nurse neglected to change a gastric tube stoma dressing. Resident #2 alleged the nurse handed her the gauze dressing and told her to do it herself. 3. On 3/12/2025 the facility failed to report to the state agency an allegation of abuse with rough incontinent care, when Resident #3 alleged her diaper grabbed and pulled up to give her wedgy. 4. On 3/13/2025 the facility failed to report to the state agency an allegation of verbal abuse when Resident #4 alleged staff insulted him by stating he smelled like an animal. These failures could have harmed residents by not having their allegations of ANE reported. The findings included: 1. A record review of Resident #1's admission record dated 6/19/2025, revealed an admission date of 3/23/2025 with diagnoses which included cerebral vascular accident (a stroke) and seizures (a surge of electrical activity in the brain). A record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was a [AGE] year-old-female admitted for long term care and assessed with a BIMS score of 9 out of a possible 15 which indicated moderate cognitive impairment. A record review of Resident #1's care plan dated 6/19/2025 revealed, I have impaired cognitive function AEB SEVERE IMPAIRMENT ON MY BIMS r/t neurological symptoms . Engage the resident in simple activities that avoid overly demanding tasks. I have a communication impairment due to no speech pattern but able to communicate with gestures & mouthing words. o Utilize nonverbal cues and gestures to communicate with resident (continued on next page)

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	455450	A. Building B. Wing	06/20/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #1's grievance report dated 12/03/2024 revealed the previous administrator documented a grievance report on behalf of Resident #1 when Resident #1's representative made an allegation of abuse. The previous Administrator documented, [Resident #1's representative] reported that her [Resident #1] called her yesterday afternoon. She stated that [Resident #1] had complained that a female nurse had treated her poorly. [Resident #1's representative] stated that her [Resident #1] began to cry and this is rare for her to do. 2. A record review of Resident #2's admission record, dated 6/19/2025, revealed an admission date of 8/9/2024 and a discharge date of 1/31/2025 with diagnoses which included encounter for attention to gastrostomy (aka a feeding tube, a device that's inserted into the stomach through the abdomen. It's used to supply nutrition and medications, aka percutaneous endoscopic gastrostomy (PEG), G tube.) A record review of Resident #2's quarterly MDS assessment dated [DATE] revealed Resident #2 was a [AGE] year-old-female admitted for rehabilitation care. Resident #2 was assessed with a BIMS score of 14 out of a possible 15, which indicated intact cognition. A record review of Resident #2's care plan dated 1/31/2025 revealed, require assistance ADL's due to generalized weakness, . Bed Mobility: I require extensive assistance in self-performance with 2-person physical assistance staff support. Dressing: I require extensive assistance in self-performance with 1-person physical assistance staff support. Eating G-tube: I am NPO. I require total assistance in self-performance with 1-person physical assistance staff support. I require total nutrition and hydration through my gastrostomy tube A record review of Resident #2's grievance report dated 12/23/2024 revealed the DON documented Resident #2 alleged a night nurse came in her room handed her a gauze and told her to change her PEG dressing herself. RN did not clean site or assist her, only left room. During an interview on 6/20/2025 at 10:50 AM the DON stated she did not recall the grievance report dated 12/3/2024 for Resident #1 nor the grievance report for Resident #2 dated 12/23/2024 but did state all grievance reports were reviewed by the IDT which included the previous Administrator who would have been the ANE prevention coordinator at the time. The DON stated she had not reported the allegations made in the grievance reports to the state agency and the reporting could have been made by the previous Administrator. 3. A record review of Resident #3's admission record dated 6/19/2025 revealed an admission date of 3/25/2025 and a discharge date of 4/24/2025 with diagnoses which included end stage renal disease (kidneys no longer work as they should to meet the body's needs and dialysis is required), severe obesity, and acquired absence of left leg above the knee. A record review of Resident #3's discharge MDS assessment dated [DATE] revealed Resident #3 was a [AGE] year-old female admitted for rehabilitation and assessed with a BIMS score of 15 out of a possible 15 which indicated intact cognition. (continued on next page)

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	455450	A. Building B. Wing	06/20/2025

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #3's care plan dated 4/24/2025 revealed, I have had Amputation of AKA to left leg . Monitor/document emotional status of resident. Observe residents' acceptance of body image changes, ability to cope with physical changes. Be supportive. Encourage resident to vent fears, concerns, and any other relevant feelings. Monitor/document pain management. Document frequency, duration, intensity of pain, phantom pain. Report to physician if medications are not effective. I require limited to extensive assistance ADL's . toileting: I require supervision, limited to extensive assistance in self-performance with 1-person physical assistance staff support A record review of Resident #3's grievance report dated 3/12/2025 revealed the SW documented Resident #3 alleged a lady provided rough incontinent care causing soreness to her amputated leg, Afro-American lady 10:00 PM came in to ask change was needed and was rough. Diaper grabbed and pulled up to give her a wedgie. Diaper had to be loosened to breathe. [Resident #3] felt she was inconvenienced 2x's. She was wiped roughly by the aide. A turned her rough. Amputated leg is sore. During an interview on 6/19/2025 at 3:50 PM the ADON stated she recalled discussing the allegation from Resident #3 with the DON and the Administrator and the resident could not recall the incident the next day and there were no staff that worked that day that fit the description. The ADON stated she had not reported the allegation to the state agency and the reporting could have been made by the Administrator. 4. A record review of Resident #4's admission record dated 6/19/2025 revealed an admission date of 8/12/2024 with diagnoses which included adjustment disorder with depressed mood (a mood disorder that causes a persistent feeling of sadness and loss of interest. it affects how you feel, think and behave and can lead to a variety of emotional and physical problems) and Parkinson's disease (a movement disorder of the nervous system that worsens over time). A record review of Resident #4's quarterly MDS assessment dated [DATE] revealed Resident #4 was a [AGE] year-old male admitted for long term care and assessed with a BIMS score of 8 out of a possible 15 which indicated moderate cognitive impairment. A record review of Resident #4's care plan dated 6/19/2025 revealed, sic[Resident #4] requires staff assistance with ADL Self Care Performance due to dementia . BATHING: [NAME] requires X 1 staff participation with bathing . has hx of depression . Monitor/document report to Nurse/MD s/sx of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness A record review of Resident #4's grievance report dated 3/13/2025 revealed the SW documented Resident #4's alleged verbal abuse, [Resident #4] said very early in the morning a CNA Afro-American doesn't remember name came into room with another CNA and told him that he smelled like an animal. A record review of the Texas Unified Licensure Information Portal (a database for incidents and allegations of ANE) website https://txhhs.my.salesforce.com/?ec=302&startURL=%2Fvisualforce%2Fsession%3Furl%3Dhttps%253A%252F%252Ftxhhs.lightning.force.com%252Flightning%252F accessed 6/19/2025, revealed no evidence of a report for the alleged instances of ANE from the period of 12/3/2024 to 6/19/2025 (continued on next page)

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	455450	A. Building B. Wing	06/20/2025

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	455450	A. Building B. Wing	06/20/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, had evidence that all alleged violations were thoroughly investigated, prevented further potential abuse, neglect, exploitation, or mistreatment while the investigation was in progress. for 4 of 10 residents (Resident #1, #2, #3, #4) reviewed for the allegations of abuse, neglect, exploitation and or mistreatment. 1. On 12/3/2024 the facility failed to investigate an allegation of abuse and or mistreatment when Resident #1's Representative alleged a nurse treated Resident #1 poorly and made Resident #1 cry. 2. On 12/23/2024 the facility failed to investigate an allegation of neglect and or mistreatment when Resident #2 alleged a nurse neglected to change a gastric tube stoma dressing. Resident #2 alleged the nurse handed her the gauze dressing and told her to do it herself. 3. On 3/12/2025 the facility failed to investigate an allegation of abuse with rough incontinent care, when Resident #3 alleged diaper grabbed and pulled up to give her wedgy. 4. On 3/13/2025 the facility failed to investigate an allegation of verbal abuse when Resident #4 alleged staff insulted him by stating he smelled like an animal. These failures could have harmed residents by not having their allegations of ANE investigated. The findings included : 1. A record review of Resident #1's admission record dated 6/19/2025, revealed an admission date of 3/23/2025 with diagnoses which included cerebral vascular accident (a stroke) and seizures (a surge of electrical activity in the brain). A record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was a [AGE] year-old-female admitted for long term care and assessed with a BIMS score of 9 out of a possible 15 which indicated severe cognitive impairment. A record review of Resident #1's care plan dated 6/19/2025 revealed, I have impaired cognitive function AEB SEVERE IMPAIRMENT ON MY BIMS r/t sic [related to] neurological symptoms . Engage the resident in simple activities that avoid overly demanding tasks. I have a communication impairment due to no speech pattern but able to communicate with gestures & mouthing words. Utilize nonverbal cues and gestures to communicate with resident A record review of Resident #1's grievance report dated 12/03/2024 revealed the previous administrator documented a grievance report on behalf of Resident #1 when Resident #1's representative made an allegation of abuse. The previous administrator documented, [Resident #1's representative] reported that her [Resident #1] called her yesterday afternoon. She stated that [Resident #1] had complained that a female nurse had treated her poorly. [Resident #1's representative] stated that her [Resident #1] began to cry and this is rare for her to do. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455450	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A record review of Resident #2's admission record, dated 6/19/2025, revealed an admission date of 8/9/2024 and a discharge date of 1/31/2025 with diagnoses which included encounter for attention to gastrostomy (aka a feeding tube, a device that's inserted into the stomach through the abdomen. It's used to supply nutrition and medications, aka percutaneous endoscopic gastrostomy (PEG), G tube.) A record review of Resident #2's quarterly MDS assessment dated [DATE] revealed Resident #2 was a [AGE] year-old-female admitted for rehabilitation care. Resident #2 was assessed with a BIMS score of 14 out of a possible 15, which indicated intact cognition. A record review of Resident #2's care plan dated 1/31/2025 revealed, require assistance ADL's due to generalized weakness, . Bed Mobility: I require extensive assistance in self-performance with 2-person physical assistance staff support. Dressing: I require extensive assistance in self-performance with 1-person physical assistance staff support. Eating G-tube: I am NPO. I require total assistance in self-performance with 1-person physical assistance staff support. I require total nutrition and hydration through my gastrostomy tube A record review of Resident #2's grievance report dated 12/23/2024 revealed the DON documented Resident #2 alleged a night nurse came in her room handed her a gauze and told her to change her PEG dressing herself. RN did not clean site or assist her, only left room. During an interview on 6/20/2025 at 10:50 AM the DON stated she did not recall the grievance report dated 12/3/2024 for Resident #1 nor the grievance report for Resident #2 dated 12/23/2024 but did state all grievance reports were reviewed by the IDT which included the previous administrator who would have been the ANE prevention coordinator at the time. The DON stated she had investigated but not reported the results of the investigation to the state agency. 3. A record review of Resident #3's admission record dated 6/19/2025 revealed an admission date of 3/25/2025 and a discharge date of 4/24/2025 with diagnoses which included end stage renal disease (kidneys no longer work as they should to meet the body's needs and dialysis is required), severe obesity, and acquired absence of left leg above the knee. A record review of Resident #3's discharge MDS assessment dated [DATE] revealed Resident #3 was a [AGE] year-old female admitted for rehabilitation and assessed with a BIMS score of 15 out of a possible 15 which indicated intact cognition. A record review of Resident #3's care plan dated 4/24/2025 revealed, I have had Amputation of AKA to left leg . Monitor/document emotional status of resident. Observe residents' acceptance of body image changes, ability to cope with physical changes. Be supportive. Encourage resident to vent fears, concerns, and any other relevant feelings. Monitor/document pain management. Document frequency, duration, intensity of pain, phantom pain. Report to physician if medications are not effective. I require limited to extensive assistance ADL's . toileting: I require supervision, limited to extensive assistance in self-performance with 1-person physical assistance staff support (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #3's grievance report dated 3/12/2025 revealed the SW documented Resident #3 alleged a lady provided rough incontinent care causing soreness to her amputated leg, Afro-American lady 10:00 PM came in to ask change was needed and was rough. Diaper grabbed and pulled up to give her a wedgie. Diaper had to be loosened to breathe. [Resident #3] felt she was inconvenienced 2x's. She was wiped roughly by the aide. A turned her rough. Amputated leg is sore. During an interview on 6/19/2025 at 3:50 PM the ADON stated she recalled discussing the allegation from Resident #3 with the DON and the administrator and Resident #3 could not recall the incident the next day and there were no staff that worked that day who fit the description. The ADON stated she had not reported the results of the investigation to the state agency and the reporting could have been made by the Administrator. 4. A record review of Resident #4's admission record dated 6/19/2025 revealed an admission date of 8/12/2024 with diagnoses which included adjustment disorder with depressed mood (a mood disorder that causes a persistent feeling of sadness and loss of interest. it affects how you feel, think and behave and can lead to a variety of emotional and physical problems) and Parkinson's disease (a movement disorder of the nervous system that worsens over time). A record review of Resident #4's quarterly MDS assessment dated [DATE] revealed Resident #4 was a [AGE] year-old male admitted for long term care and assessed with a BIMS score of 8 out of a possible 15 which indicated severe cognitive impairment. A record review of Resident #4's care plan dated 6/19/2025 revealed, sic[Resident #4] requires staff assistance with ADL Self Care Performance due to dementia . BATHING: [NAME] requires X 1 staff participation with bathing . has hx of depression . Monitor/document report to Nurse/MD s/sx of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness A record review of Resident #4's grievance report dated 3/13/2025 revealed the SW documented Resident #4's alleged verbal abuse, sic[Resident #4] said very early in the morning a CNA Afro-American doesn't remember name came into room with another CNA and told him that he smelled like an animal. During an interview on 6/19/2025 at 3:50 PM the ADON stated she recalled discussing the allegation from Resident #4 with the DON and the administrator and the Resident could not recall the incident the next day and there were no staff that worked that day fit the description. During an interview on 6/18/2025 at 4:40 PM the Administrator reviewed the grievance reports for residents as follows: 1. On 12/3/2024 Resident #1's Representative alleged a nurse treated Resident #1 poorly and made Resident #1 cry. 2. On 12/23/2024 Resident #2 alleged a nurse neglected to change a gastric tube stoma dressing. Resident #2 alleged the nurse handed her the gauze dressing and told her to do it herself. 3. On 3/12/2025 Resident #3 alleged diaper grabbed and pulled up to give her wedgy. 4. On 3/13/2025 Resident #4 alleged staff insulted him by stating he smelled like an animal. (continued on next page)

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	455450	A. Building B. Wing	06/20/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the Texas Unified Licensure Information Portal (a database for incidents and allegations of ANE) website https://txhhs.my.salesforce.com/?ec=302&startURL=%2Fvisualforce%2Fsession%3Furl%3Dhttps%253A%252F%252Ftxhhs.lightning.force.com%252Flightning%252F accessed 6/19/2025, revealed no evidence of a report for the alleged instances of ANE from the period of 12/3/2024 to 6/19/2025 The administrator stated all the grievances reviewed would have warranted a report of alleged ANE to the state agency. The administrator stated he was not the administrator in December 2024 but was the administrator during March 2025. The administrator stated he had not recognized the grievances as reportable allegations of ANE at the time. The Administrator stated the risks to residents could be their allegations of ANE would not be reported. A record review of the facility's Reporting Allegations or Suspicions of Abuse undated policy revealed, Report alleged or suspicions of abuse to HHSC by email reporting or via TULIP reporting within the designated time frames in accordance with HHSC . - are reported immediately, - but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, - or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury,

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to send a copy of the residents' discharge notice, prior to discharge, to the representative of the Office of the State Long-Term Care (LTC) Ombudsman of the residents' transfer or discharge and the reasons for the move, for 1 of 8 residents (Resident #8) reviewed for notifying the LTC Ombudsman of the residents' discharge. Resident #8 was discharged on 12/2/2024 without a notice to the LTC state ombudsman. This failure could place residents at risk of not knowing their rights or receiving the services of the state LTC Ombudsman. The findings included: A record review of Resident #8's admission record dated 6/19/2025 revealed an admission date of 9/5/2024 with diagnoses which included Guillain-Barre disease (a condition in which the body's immune system attacks the nerves. It can cause weakness, numbness, or paralysis), respiratory failure, and a tracheostomy (a hole that surgeons make through the front of the neck and into the windpipe, also known as the trachea, to facilitate respirations). A record review of Resident #8's discharge MDS assessment revealed Resident #8 was a [AGE] year-old male admitted for LTC and discharged , for elevated care at a hospital, without an expectation for a return to the facility. A record review of Resident #8's medical record revealed no evidence of a discharge notice to the state ombudsman. During an interview on 6/17/2025 at 3:19 PM the state Ombudsman stated she had no evidence the facility had notified her of Resident #8's discharge. The Ombudsman stated she visited the facility often and had had few notices from the facility. During an interview on 6/19/2025 at 3:45 PM the SW stated she has been the facility's SW since March 2025 and has been directed by the Administrator to not coordinate with the ombudsman. The SW stated she had no evidence for a report to the state Ombudsman for Resident #8's discharge. The SW stated a record review of Resident #8's medical record revealed Resident #8's representative was dissatisfied with his health status and wished to discharge Resident #8 as soon as possible to the hospital. The SW stated the IDT cooperated for a safe discharge. The resident chose a hospital out of town. During an interview on 6/19/2025 at 4:04 the DON stated she was not aware of any reports for discharges of residents to the state ombudsman. During an interview on 6/19/2025 at 4:20 PM the Administrator stated he was not the administrator in December 2024 when Resident #8 was discharged and was unaware of the rule to notify the state ombudsman of any resident discharges. The Administrator stated a review of Resident #8's records could not evidence a notice to the state ombudsman for Resident #8's discharge. (continued on next page)

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	455450	A. Building B. Wing	06/20/2025

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's Transfer or Discharge, Resident-Initiated Policy Statement dated October 2022, revealed, Residents may initiate a transfer or discharge from the facility. Policy Interpretation and Implementation: . 3. Resident-initiated transfer or discharge means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility . Required Notices: 1. For resident-initiated transfers or discharges, sending a copy of the resident's notice of intent to leave the facility to the ombudsman is not required.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations, interviews, and record reviews the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 2 of 4 medication carts reviewed for security and control, in that: 1. LVN E left the 100-hall medication cart unattended, unsupervised, and unlocked. 2. RT K left the 200-hall respiratory therapy medication cart unattended, unsupervised, and unlocked. These failures could place residents at risk of misappropriation of property, not receiving the therapeutic effects of medications, and or adverse effects of medications. The findings included: During an observation and interview on 6/17/2025 at 12:34 PM revealed the medication cart for the 100-hall was unattended, unsupervised, and unlocked while parked on the hall, as evidenced by the protruding unlocked mechanism. The cart was observed for 10 minutes while residents and CNAs ambulated in the hall. Continued observation revealed the ADON approached the medication cart and locked the cart. The ADON stated the cart was assigned to a nurse, but she was unaware of the nurse's name. The ADON stated she was also unaware of the nurse's whereabouts. The ADON stated the medication cart had medications, to include narcotics, stored within. The ADON stated the expectation was for medication carts to be locked when not attended. During an observation and interview on 6/17/2025 at 1:09 PM revealed the 200-hall respiratory therapy medication cart was unattended, unsupervised, and unlocked while parked on the 200-hall, as evidenced by the protruding unlocked mechanism. Continued observation revealed CNAs and residents ambulated by the cart. After 5 minutes of observations CNA I stated the cart belonged to RT K and pointed him out by the nurse's station. RT K was informed of his unattended and unsupervised medication cart to which he stated, I was in a resident's room providing care . I could not see my cart while I was in the room. During an interview on 6/17/2025 at 1:20 PM the ADON stated she learned the 100-hall medication cart was assigned to LVN E. During an interview on 6/17/2025 at 1:50 PM LVN E stated she left the medication cart unlocked due to human error. During an interview on 6/20/2025 at 12:28 PM the DON stated the expectation was for all medication carts to be locked when not attended by nursing staff and the risk to residents could be not receiving the therapeutic effects of their medications. (continued on next page)

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	455450	A. Building B. Wing	06/20/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the facility's Security of Medication Cart policy dated April 2007 revealed, Policy heading: The medication cart shall be secured during medication passes. Policy Interpretation and Implementation: . 3. When it is not possible to park the medication cart in the doorway, the cart should be parked in the hallway against the wall with doors and drawers facing the wall. The cart must be locked before the nurse enters the resident's room. 4. Medication carts must be securely locked at all times when out of the nurse's view. 5. When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room.

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	455450	A. Building B. Wing	06/20/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to maintain medical records on each resident that were complete, accurately documented, readily accessible, and were systematically organized, for 1 of 8 residents (Resident #8) reviewed for consents for accurate medical records. Resident #8's November 2024 treatment administration report had no documentation for his prescribed daily wound care for the wound on his sacrum (a single bone comprised of five separate vertebrae. It is shaped like an upside-down triangle and sits at the bottom of the spinal column, connecting it to the pelvis) on the following dates: o 11/10/2024 , o 11/15/2024, o 11/20/2024, o 11/21/2024, and, o 11/24/2024. The failure could place residents at risk for inaccurate and unorganized medical records. The findings included: A record review of Resident #8's admission record dated 6/19/2025 revealed an admission date of 9/5/2024 with diagnoses which included Guillain-Barre disease (a condition in which the body's immune system attacks the nerves. It can cause weakness, numbness, or paralysis), respiratory failure, and a tracheostomy (a hole that surgeons make through the front of the neck and into the windpipe, also known as the trachea, to facilitate respirations). A record review of Resident #8's discharge MDS assessment dated [DATE], revealed Resident #8 was a [AGE] year-old male admitted for LTC and discharged , for elevated care at a hospital, without an expectation for a return to the facility. A record review of Resident #8's care plan dated 12/2/2024 revealed, I am at risk for skin breakdown, and I am at risk for new pressure ulcers due to my impaired mobility, I also have current skin breakdown that requires treatment: pressure injury to sacrum . Treatment per MD orders A record review of Resident #8's physician's orders and treatment record dated November 1, 2024, revealed Resident #8 was prescribed daily wound care, clean wound on sacrum with NS sic[normal saline] using 4x4 gauze, pat dry using 4x4 gauze, lightly pack wound with calcium alginate rope, apply dressing daily and PRN sic[as needed]. Further review revealed the following dates did not have documented evidence of wound care as evidenced by blanks in the treatment record: o 11/10/20204, (continued on next page)

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	455450	A. Building B. Wing	06/20/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o 11/15/2024, o 11/20/2024, o 11/21/2024, and, o 11/24/2024. During an interview on 6/17/2025 at 1:10 PM Resident #8's representative stated the facility had neglected to care for the resident in general and provided poor wound care and stated, He had an order for wound care daily and PRN He was lucky to receive the wound care daily, never received a PRN wound care until I bought dressings and started replacing the dressings myself. During an interview on 06/18/2025 at 10:22 AM the ADON stated she was not the ADON during September through December 2024. The ADON stated the expectation for nursing staff was to document all care provided in the residents record as soon as the care was provided, usually by the end of their daily shift. The ADON stated she reviewed Resident #8's November 2024 treatment administration record specifically for wound care and recognized the lack of documentation for the dates: o 11/10/20204, o 11/15/2024, o 11/20/2024, o 11/21/2024, and, o 11/24/2024. During an interview on 6/19/2025 at 4:20 PM the DON stated Resident #8 was admitted with a sacrum wound and was receiving wound care daily and as needed. The DON stated Resident #8's wound was attended and followed by a wound care physician and was slowly improving throughout November and December 2025. The DON stated Resident #8's representative was unhappy with Resident #8's general stay at the facility and voiced her wishes for Resident #8 to be discharged to an out-of-town hospital. The DON stated the Resident was supported with the discharge. The DON stated she was unaware of the holes in the November wound care treatment administration record (TAR). The DON stated the expectation was for the nursing staff to document the care provided as soon as the care was provided. The DON stated she believed Resident #8 had received all his wound care as evidenced by the wound care physicians' documentation of the improved wound . The DON stated the risk for residents with holes in the TAR was for inaccurate records. A record review of the facility's Charting Errors and/or Omissions policy dated December 2006, revealed, Policy Statement: Accurate medical records shall be maintained by this facility.