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	08/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Care Monte Vista	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)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility personnel failed to provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for 1 of 6 residents (Resident #1) whose records were reviewed for code status. Facility staff failed to follow emergency protocol, did not obtain an AED, did not obtain the crash cart, or continue CPR until EMS arrived after Resident #1, and who had a Full Code in place, was found unresponsive with no pulse or respirations. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 9:11 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity of potential for more than minimal harm due to the facility's need to evaluate the effectiveness of their plan of removal. This failure could place residents at risk of not receiving life-saving measures, decline in health resulting in serious injury and or death. The findings included: Record review of Resident #1's face sheet, dated [DATE], reflected she was an [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE] with dependence on respirator [ventilator] status (patient requires mechanical ventilation to breathe independently due to respiratory failure), dependence on supplemental oxygen, paroxysmal atrial fibrillation (an episode of atrial fibrillation that results in uncoordinated movement of the atria), acute systolic (congestive) heart failure (heart's inability to pump blood effectively, leading to fluid buildup in the body), chronic obstructive pulmonary disease with acute exacerbation (sudden worsening of respiratory symptoms characterized by obstructed airflow that makes it difficult to breathe) and cerebral infarction (occurs when a blood vessel in the brain is blocked, preventing oxygen and nutrients from reaching the brain tissue). Record review of Resident #1's care plan, close date [DATE], revealed the resident was full code status (a patient wishes to recieve all resuscitation efforts and life-saving measures during a medical emergency) and to being CPR after absence of vitals signs, call 911, call physician to notify, ensure staff are aware of code status through designated system, and full code order in chart. Record review of Resident #1's physician orders, dated [DATE], revealed an order for full code with start date of [DATE], and no end date. Record review of Resident #1's progress notes, dated [DATE], revealed:-A note Written by LVN C on [DATE] at 2:45 a.m. Patient was breathing while sleeping when this nurse got to her room to check on her. her vitals were WNL this was about an hour ago before she had an attack. the aids were doing their rounds when they found out she was not breathing, and the nurse was notified which they immediately started CPR on the patient and Ems was called. when they arrived, they tried to revive the patient to no avail she had passed on. Dr.notified.-A note written by RT E on [DATE] at 3:12 a.m. pt expired around 2300. CNA called me to check on patient because she looked pale. PT was unconscious. I checked her o2 sat and her exhaled tidal volumes. Her volumes were of 404 and she didnt have a pulse. We checked her code status and began CPR. During an observation on 8/225 at 1:08 p.m. the facility had an AED by the nurses' station which contained pads with an expiration date of [DATE]. The AED green light indicator, indicated it was in working order. There was a crash cart with various supplies including an Ambu bag (manual resuscitator is a handheld medical device used to provide positive pressure ventilation to patients who are not breathing). During an interview on [DATE] at 12:44 p.m. EMS F stated they were dispatched to a call for Resident #1 at 11:24 p.m. Upon arrival to the facility at 11:26 p.m. the patient was the only person in the room at 11:30 p.m., no care was being provided, and it did not appear that any care had been provided prior to their arrival. Resident #1 was found pulseless and apneic (not breathing). EMS F stated staff told them the resident was full code and did not have a DNR. EMS F stated there were no signs of lividity (bluish-purple discoloration of the skin that occurs after death) or rigor mortis. (stiffening of the body after death) EMS F stated they moved the resident from the bed to the floor and began CPR. EMS F stated the resident was found to be in asystole (absence of electrical activity in the heart). EMS F stated a medical director was contacted and advised to cease efforts and the time of death was 11:52 p.m. During an interview on [DATE] at 3:58 p.m. LVN D stated she was called to the 2nd floor of the building by CNA A and CNA B to check on Resident #1 because she was not breathing and could not find LVN C to help. LVN D stated she went to Resident #1's room, she found her not breathing, pulseless, and began CPR in the resident's bed while holding the phone with her cheek calling 911 and performing compressions. LVN D stated she instructed CNA B to go find the LVN C and CNA A to go find RT E. LVN D stated CNA A returned with RT E. LVN D stated she asked the aide and RT if the