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 03/20/2026
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)
F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive for 1 of 10 (Resident #1) reviewed for advance directives. The facility failed to honor Resident #1's Out-of-Hospital Do Not Resuscitate (OOH DNR) when on [DATE] the resident was found unresponsive and was resuscitated after respirations and pulse ceased. The non-compliance was identified as PNC. The Immediate Jeopardy (IJ) began on [DATE] and ended on [DATE]. The facility corrected the non-compliance before the survey began on [DATE]. This failure could place residents at risk of pain associated with resuscitation and mental anguish.The findings included: Record review of Resident #1's face sheet, dated [DATE], revealed a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses that included: depression, anxiety disorder, ALS (fatal neurodegenerative disease that causes nerves in the brain and spinal cord to degenerate, resulting in muscle weakness), and tracheostomy (surgical opening made in the neck to create an airway for breathing using a ventilator). Record review of Resident #1's comprehensive MDS assessment, dated [DATE], revealed a BIMS of 15. Record review of Resident #1's CP, dated [DATE], revealed Resident #1was care planned for code status DNR. Record review of Resident #1's OOH DNR revealed the document was signed on [DATE] by the physician and two witnesses. Record review of Resident #1's physician order, dated [DATE], revealed Resident #1's advance directive was DNR. Record review of Resident #1's progress note, dated [DATE], revealed Resident #1 was found unresponsive at 6:38 PM by CNA B. CNA B informed LVN C, and LVN C checked Resident #1 for a pulse and found it weak, but Resident #1 was breathing. LVN A entered the room and did a sternal rub (painful stimuli used to assess consciousness) with no response. LVN C checked for a pulse in Resident #1's wrist, groin, and behind the knee and found no pulse. LVN A called a code, and CPR started at 6:40 PM. Record review of in-services: Timely Emergency Services & Professional Standards for CPR; How to Identify the Resident Code Status; and Abuse & Neglect dated [DATE] revealed all staff received in-service trainings. All new hires with start date [DATE] and beyond were required to have the in-service trainings as well. Record review of the CPR certifications for LVN F, LVN A, and RT D, who participated in the code blue of Resident #1, revealed all were valid. During an interview with LVN A on [DATE] at 12:59 PM, LVN A said LVN C was informed by agency CNA B that Resident #1 was unresponsive. LVN A said LVN C went into the room to do an assessment and found Resident #1 to have a weak pulse and breathing. LVN A said she entered the room to do an assessment because the nurse assigned to Resident #1 was busy. LVN A said she attempted to get a response from Resident #1 by doing a sternal rub, and she shook Resident #1, but Resident #1 did not respond. LVN A said while she assessed Resident #1, LVN C checked Resident #1's pulse and found nothing in her wrist, behind her knee, and her groin. LVN A said Resident #1 had stopped breathing. LVN A said she called CODE BLUE, and RT D removed the breathing circuit (components that deliver oxygen to the tracheostomy) from Resident #1's tracheostomy, began suctioning Resident #1 and then RT D started to use the ambu bag (hand-held manual resuscitator) for breaths. LVN A said LVN C (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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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the binders were updated daily by the night shift, the ADONs checked the binders to make sure they were correct and there was a copy of the DNR in the binder for each resident. During an interview on [DATE] 3:34 PM, CNA O said she received in-service for abuse and neglect and they would have it frequently. CNA O said she had the in-service for DNRs as well on the same day. She said she learned the DNRs were kept in the binder on the crash cart and was updated every day with the names highlighted that were DNRs. CNA O said there was a copy of the DNR in the binder, and she could also look in the computer to see if a resident was a DNR or not because they used the computer to find out how to care for a resident. CNA O said if she saw a resident that was not responding, she would get the nurse immediately and follow instructions given to her. During an interview on [DATE] at 9:41 AM, LVN K (worked 10PM-6AM) said she worked the night shift and was responsible for printing out the DNR list to be placed in a binder on the crash cart. LVN K said it was done daily using the midnight census. LVN K said the previous way was if a code was called for a resident, CPR was started until it was verified and once it was verified, either it would be stopped or continue with CPR. LVN K said even if the person was new, and knew nothing about the code status, it should be on the census sheet because when it was printed on the midnight census, the name should be highlighted and placed in the binder on the crash cart with a copy of the DNR. During an interview with EMS on [DATE] at 10:08 AM, EMS said the call came in on [DATE] at 6:43 PM and three units were dispatched to the facility in response to the Cod Blue for Resident #1. The first unit arrived at 6:45 PM; the second arrived at 6:46 PM; and the third unit arrived at 6:48 PM. During a telephone interview with CNA B (agency) on [DATE] at 10:13 AM, CNA B said she went to Resident #1's room to do rounds and found the resident unresponsive. CNA B said she told LVN C that Resident #1 was unresponsive and LVN C went to the room to assess Resident #1. CNA B said RT D went into the room and suctioned Resident #1. CNA B said when LVN A entered the room and tried to wake Resident #1, LVN C told LVN A there was no pulse and Resident #1 stopped breathing. CNA B said LVN A called a code and told her to call 911. CNA B said another RT (RT E) entered the room and another LVN F came into the room to help with CPR. CNA B said while she called 911, LVN A looked for the crash cart binder for Resident #1's DNR. CNA B said there seemed to be a discrepancy about whether she was a DNR or not because it said she was in one place and another place Resident #1 was not, so LVN A was not sure. CNA B said LVN A found out Resident #1 was a DNR after EMS arrived, and LVN A informed them that Resident #1 was a DNR. CNA B said she did not have the in-service because she had not been back to the facility since that incident During an interview with the SW on [DATE] at 11:58 PM, the SW said if a resident was already at the facility and decided to become a DNR, she had a form and she would find out if the resident was their own responsible party or if they had one. The SW said she would verify with the RP and once the document was signed, she would give it to the DON to update the electronic medical record. During an interview with Resident #1's RP on [DATE] at 12:17 PM, Resident #1's RP said she signed a DNR on [DATE] she believed. The RP said the doctors at the hospital told her that Resident #1 would not live much longer because the CPR rushed blood to her head. The RP said hospice went to the facility to get a copy of the DNR to transport her to a facility for hospice care where she expired early the next day. The RP said the DNR was in place because Resident #1 said she did not want her ribs cracked. The RP said another DNR was done after Resident #1 admitted to the facility with the one from the hospital because they told her she needed one from the facility. The RP said she was called Monday evening, [DATE], and told Resident #1 was found unresponsive and transported to the hospital. The RP stated the family went to the hospital and spent some time with Resident #1. The RP said at that point, they knew if Resident #1 recovered, the resident would not be in the same frame of mind. The RP said the facility did not abide by Resident #1's wishes. During an interview with RT D on [DATE] at 3:11 PM, RT D said he was called to assist with Resident #1 and when he walked into the room, a nurse (LVN A) and a CNA (CNA B) were working with Resident #1. RT D said he checked Resident #1's airway and suctioned Resident #1. RT D said RT E came in the room as well and took Resident #1 off the (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ventilator and used the ambu bag until EMS arrived. RT D said he checked the airway and suctioned the Resident #1. RT D said RT E entered the room as well. RT D said RT E took her off he ventilator and used the ambu bag until EMS arrived and RT D said he grabbed the backboard and moved to allow EMS to work. RT D said he had the in-services, and he learned that the census was printed by the night nurses and they highlighted all the names of the residents that were DNRs and then put them in the binder on the crash cart on each floor. During an interview with the ADM on [DATE] at 3:48 PM, the ADM said she was not aware Resident #1 was a DNR, but once they were told that she coded, all managers immediately went to the facility to investigate why the resident was resuscitated when she was a DNR. The ADM said she, the DON, and ADONs for each floor in-serviced the staff about resident rights with: Timely Emergency Services & Professional Standards for CPR, How to Identify the Resident Code Status, and Abuse & Neglect. The ADM said going forward, they implemented that every day, the night shift nurses would print out the resident census sheets and highlight the names of the residents that were DNRs and place the sheets in the crash cart binder along with the copy of the DNR. The ADM said the census would have the date it was printed and that was a way to validate it was done. The ADM said on the morning shift, the ADONs for each floor would check the crash cart binder for accuracy and for any updates of DNR code status that were needed and the DON also checked code status. The ADM said the residents' rights should be respected to maintain a healthy quality of life for them. The ADM said all new hires with start date [DATE] and beyond were required to have the in-service trainings as well. During interview and observation on [DATE] at 4:50 PM, the DON said they implemented the plan for the night shift nurses to print the daily census and placed them in the crash cart binder with the residents' names highlighted that were DNRs. The DON said the date would be printed and that was a way to have accountability. The DON said there was also a weekly SOC (standard of care) on a spreadsheet that was mandatory to complete. The DON said on the spreadsheet, there was a column for DNR and if there was a change, the date for the change by the name of the resident would be there. The DON said the spreadsheet was an internal document that the facility's corporate nurse tracked. The DON said audits were done on a printed report for new admits checking for code status and updating the crash cart binders. The DON said also, when there was a DNR done with the SW, the SW would deliver the DNR to the DON and she would update it in the resident's electronic medical record, and add it to the crash cart binder, and updated in the SOC that was done weekly. The facility implemented a plan for the DON to audit resident charts for DNRs weekly for four weeks, also SOCs done weekly would be audited by the corporate nurse for the facility. Record review of in-services: Timely Emergency Services & Professional Standards for CPR; How to Identify the Resident Code Status; and Abuse & Neglect dated [DATE] revealed all staff received in-service trainings. All new hires with start date [DATE] and beyond were required to have the in-service trainings as well. Record review of LVN F, LVN A, and RT D who participated in the code blue of Resident #1 revealed all CPR certifications were valid. During an interview on [DATE] at 12:30 PM, LVN N said the crash cart binder was updated daily by the nurses on nigh shift. LVN N said the new printed copy would be placed in the crash cart binder with the names highlighted. The LVN said if a resident was unresponsive with no breath or pulse, staff should check the crash cart binder that was checked daily by the ADONs for accuracy as a way for accountability to not have an error as before with Resident #1. During an interview on [DATE] at 9:30 AM, ADON Q2 said she was responsible for ensuring the crash cart binder's census sheet was printed with the residents who were DNRs names highlighted. ADON Q2 said when a resident codes, the binder on the crash cart should be accurate to verify a resident's code status to prevent a resident's rights not being honored. Interview on [DATE] at 12:28 PM, LVN H said the way to identify who was a DNR was by the binder on the crash cart. LVN H said the ADONs checked the binders daily after the night shift nurses printed a new census sheet daily and the names of the residents that were DNRs were highlighted. LVN H said she had several in-services that day after a resident (Resident #1) was resuscitated who was a DNR. LVN H said there should be no mistakes because the binder was checked daily, even with new (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	admissions and the other way to check was in the medical record. Interview on [DATE] at 9:20 AM, LVN I said she knew who was a DNR on her shift 10:00 PM-6:00 AM. LVN I said there was a DNR book on the crash cart. LVN I said she printed the lists of residents who were DNRs for her floor and for the 1st floor as well because she felt it was important to know in case a code was called on another floor. LVN I said she would highlight the residents on her floor- 2nd floor. LVN I said if there was a new resident, and they may not know them, she would have someone to check the crash cart binder, and check the electronic medical records. LVN I said the binders were to be checked daily in the morning by the ADONs for each floor. Interview on [DATE] at 9:41 AM LVN K (worked 10PM-6AM) said she worked the night shift and was responsible for printing out the DNR list to be placed in a binder on the crash cart. LVN K said it was done daily using the midnight census. LVN K said the previous way was if a code was called for a resident, until it was verified and once it was verified, either it would be stopped if it was verified as a DNR or continue if they were a full code. LVN K said even if the person was new, and knew nothing about the code status, it should be on the census sheet because when it was printed on the midnight census, the name should be highlighted and placed in the binder on the crash cart with a copy of the DNR. Interview on [DATE] at 9:50 AM, RN L said she worked the night shift(10PM-6AM), and would update the binders daily on the crash cart with the residents that were DNRs highlighted. RN L said it could also be found in the electronic medical records. RN L said a hard copy of the DNR would be in the binder and it could be found in the electronic medical record under miscellaneous. RN L said she had the in-services after the incident of a resident (Resident #1) being coded that was a DNR and printing the midnight census was a part of correction and if a resident was new, a copy of the DNR would be given by the DON and the new name would be on the census when printed and the name highlighted. During an interview on [DATE] at 10:08 AM, CNA R said if she found someone who had no pulse or breath, she would inform the nurse and the nurse would initiate CODE BLUE and start CPR and would continue until the status was verified. She said there was a binder on the crash cart and there was a list of the residents that were DNRs. CNA R said since the received the in-service, they would first check the crash cart binder to make sure the resident was a DNR before starting CPR. CNA R said the names in the crash cart binder should be highlighted because the night shift nurses do it and the ADONs check them every day in the morning. Interview on [DATE] at 11:58AM the SW said she received the in-services immediately after the incident with Resident #1. The SW said the binders on the crash carts were updated and verified daily by the ADONs on each floor. The SW said the census should be printed during the night shift and the names were highlighted for the residents that were DNRs. During an interview on [DATE] at 3:55 PM, LVN M said he received an in-service for DNR along with others the same day. LVN M said he learned the crash cart binders were updated during the overnight shift when they printed the midnight census and highlighted the residents that were DNRs. LVN M said that it was supposed to ensure that a resident that was a DNR wishes would be respected. LVN M said if it was not found in the binder, he would look in the computer in the medical record of the resident and if it was a new resident, the DON would bring a copy of the DNR to the floor and give it to a nurse to place in the binder and update the name on the list. LVN M said if it was given to him, he would place it in the binder, write the name on the census sheet and put it on the 24-hour report so the night shift would be aware that way as well as the binder. During an interview on [DATE] at 4:55 PM, ADON Q1 said she received the in-services and the one for Code Blue was for her as an ADON to check the crash cart binder for the 1st floor to ensure the resident census was printed out over night by the nurses and highlighted names of the residents who were DNRs. ADON Q1 said the census date should be the following day from the previous date, which would be accountability that they're being printed. ADON Q1 said she would go through the electronic medical record of all the names on the list for the 1st floor were correct as being highlighted as DNRs. Investigator requested policy for Out-of-Hospital DNR and was informed there was no policy for Out-of-Hospital DNR, only for Resident Rights. During an interview on [DATE] at 6:30 PM, CNA S said she received the in-services for abuse and neglect and DNR. CNA S (continued on next page)

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