| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455450 | A. Building<br>B. Wing | 05/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Meridian Care Monte Vista | 616 W Russell Pl<br>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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to immediately consult with the resident's physician and notify, consistent with his or her authority, the resident representative when there is a significant change in the resident's physical, mental, or psychosocial status for 1 of 1 resident (Resident #1) reviewed for medication administration, in that: The facility failed to ensure the physician and RP were notified of missed doses of Rifaximin 550mg for hepatic encephalopathy between 04/27/2026 and 05/16/2026 due to medication not being available. This failure puts the resident at risk for not receiving therapeutic effects from their medications. The findings include: A record review of resident #1's face sheet dated 05/19/2026 revealed an admission date of 07/31/2025 with diagnoses which included hepatic encephalopathy (a condition that occurs when the liver is unable to filter toxins from the blood) and chronic kidney disease stage 4 (kidneys are moderately to severely damaged and are not properly filtering waste from the blood). A record review of resident #1's Quarterly MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. A record review of resident #1's care plan dated 02/20/2026, revealed: Resident #1 at risk for alteration in neurological status r/t hx of hepatic encephalopathy, interventions: Give medications as ordered. Monitor/document for side effects and effectiveness, and Receives Rifaximin oral as per MD orders. A record review of resident #1's physician order summary dated 05/19/2026 revealed to administer the following medications: rifaximin Oral Tablet 550 MG (Rifaximin) Give 1 tablet by mouth every 12 hours for hepatic encephalopathy, with administration time of 8:00am and 8:00pm, with a start date of 02/18/2026. A record review of resident #1's MAR in the electronic medical record revealed nursing staff did not document Rifaximin 550mg was administered but instead documented 9=Other/See Nurse Notes, during the period of 04/27/2026 - 05/16/2026 for a total of 31 doses of medication. Corresponding progress notes read Note Text: rifAXIMin Oral Tablet 550 MG, Give 1 tablet by mouth every 12 hours for Hepatic encephalopathy, pending delivery, pending pharmacy, or no supply. A record review of resident #1's progress notes during the period of 04/27/2026 - 05/16/2026 revealed no documentation that the resident's physician or RP had been informed of the missed doses of Rifaximin 550mg. During an interview on 05/20/2026 at 9:58 am with Resident #1's RP, she stated she was not made aware of Resident #1 not receiving her Rifaximin 550mg until the facility informed her on 05/19/2026, and she did not know how long she had gone without her medication. During an interview on 05/20/2026 at 10:39 am with LVN A, she stated she was aware resident#1 had run out of Rifaximin 550mg tablets. LVN A stated the proper procedure to follow when a medication is not available is to call the pharmacy, inform the ADONs and inform the physician. LVN A stated she did not notify the RP and she did not notify the physician because she thought the ADONs would inform him. LVN stated the risk to a resident missing ordered medications could cause worsening symptoms and cause the resident to become sick. During an interview on 05/20/2026 at 11:45am, ADON B stated she was not aware that resident #1's Rifaximin 550mg was unavailable, but she became aware on 05/19/2026, at which point the RP and physician were notified. ADON B stated the RP and physician should be informed when a medication is unavailable. During an interview on 05/19/2026 at<br>(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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2:10pm with the DON, she stated her expectation for an unavailable medication was that nursing staff contact the pharmacy, check the emergency medication kit, and if not available, notify the DON, physician and family. The DON confirmed there was no documentation that RP or physician were notified about Resident #1's Rifaximin being unavailable. The DON stated the risk to residents if medications were not administered as ordered could include worsening of symptoms. A record review of the facility's policy titled Resident Rights, dated 03/2021, revealed, 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: (j) be notified of his or her medical condition and of any changes in his or her condition. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administration of all drugs and biologicals) for 1 of 1 resident (Resident #1) to meet the needs of the resident, in that: The facility failed to ensure Resident #1 received ordered medication Rifaximin 550mg for hepatic encephalopathy between 04/27/2026 - 05/16/2026 due to medication being unavailable. This failure could place residents at risk for not receiving therapeutic effects from their medications. The findings included: A record review of Resident #1's face sheet dated 05/19/2026 revealed an admission date of 07/31/2025 with diagnoses which included hepatic encephalopathy (a condition that occurs when the liver is unable to filter toxins from the blood) and chronic kidney disease stage 4 (kidneys are moderately to severely damaged and are not properly filtering waste from the blood). A record review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. A record review of Resident #1's care plan dated 02/20/2026, revealed: Resident #1 at risk for alteration in neurological status r/t hx of hepatic encephalopathy, interventions: Give medications as ordered. Monitor/document for side effects and effectiveness, and Receives Rifaximin oral as per MD orders. A record review of Resident #1's physician order summary dated 05/19/2026 revealed to administer the following medications: rifaximin Oral Tablet 550 MG (Rifaximin) Give 1 tablet by mouth every 12 hours for hepatic encephalopathy, with administration time of 8:00am and 8:00pm, with a start date of 02/18/2026. A record review of Resident #1's MAR in the electronic medical record revealed nursing staff did not document Rifaximin 550mg was administered but instead documented 9=Other/See Nurse Notes, during the period of 04/27/2026 - 05/16/2026 for a total of 31 doses of medication. Corresponding progress notes read Note Text: rifAXIMin Oral Tablet 550 MG. Give 1 tablet by mouth every 12 hours for Hepatic encephalopathy, pending delivery, pending pharmacy, or no supply. Interview with the Pharmacy on 05/20/2026 at 9:30am stated that Rifaximin 550mg tablets were no longer covered by Resident #1's insurance and facility may need to submit for prior authorization. During an interview on 05/20/2026 at 10:39 am with LVN A, she stated she was aware Resident#1 had run out of Rifaximin 550mg tablets and that she had called the pharmacy on multiple occasions and faxed the medication order to the pharmacy in attempts to receive the medication. LVN A stated she informed the ADONs that prior authorization was needed. LVN A stated the proper procedure to follow when a medication was not available was to call the pharmacy, inform the ADONs and inform the physician. LVN A stated she did not notify the responsible party and she did not notify the physician because she thought the ADONs would inform him. LVN A stated the risk to a resident missing ordered medications could cause worsening symptoms and cause the resident to become sick. During an interview on 05/20/2026 at 11:45am, ADON B stated she was not aware that Resident #1's Rifaximin 550mg was unavailable, or the need for prior authorization, and that it was not reported to her by the nursing staff. ADON B stated that when she became aware on 05/19/2026, she notified the RP and the physician and obtained new orders for stat labs, new medication and monitoring. ADON B stated the facility initiated an in-service regarding medication availability and the process to follow. During an interview on 05/20/2026 at 12:15pm, ADON C stated she was not aware that Resident #1's Rifaximin 550mg was unavailable, nor was it reported to her the need for a prior authorization. ADON C stated the process to follow if a medication is unavailable was to call the pharmacy, physician and family and let them know and to document that communication. During an interview on 05/19/2026 at 2:10pm with the DON, she stated her expectation for an unavailable medication was that nursing staff contact the pharmacy, check the emergency medication kit, and if not available, notify the DON, physician and family. The DON stated she was not aware of Resident #1 not having Rifaximin 550mg available. During an interview on 05/20/2026 at 11:20am, the DON stated Resident #1's physician and<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | RP had been notified about the missed doses of Rifaximin 550mg on 05/19/2026, and new orders had been obtained and an in-service initiated. The DON stated the risk to residents if medications were not administered as ordered could include a worsening of symptoms. The DON stated there was currently Rifaximin 550mg available for Resident #1 and the facility would pay for the medication if it was not covered by insurance. A record review of the facility's policy titled, Administering Medications, dated 04/2019, revealed, 4. Medications are administered in accordance with prescriber orders, including any required time frame. |