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	11/06/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788 Based on observation, interview, and record review, the facility failed to ensure residents have a right to personal privacy for 1 of 5 residents (Resident #46) reviewed for privacy, in that: CNA A and CNA B did not close completely Resident #46's privacy curtain while providing catheter care. This deficient practice could place residents at-risk of loss of dignity due to lack of privacy. The findings include: 1. Record review of Resident #46's face sheet, dated 11/06/2024, reflected an admitted [DATE] with diagnoses which included: Dysphagia (difficulty swallowing), Type 2 diabetes mellitus (high level of sugar in the blood), Cerebral palsy (group of movement disorders that appear in early childhood) and, Spina bifida (birth defect in which there is incomplete closing of the spine). Record review of Resident #46's Admission MDS assessment, dated 10/20/2024, reflected the resident had memory problems and was severely cognitively impaired. Resident #46 was dependent for his activities of daily living, had an indwelling catheter and, was always incontinent of bowel. Record review of Resident #46's care plan, dated 10/14/2024, reflected a problem of Indwelling Catheter Type: Foley Catheter Related to: NEUROGENIC BLADDER, with a goal of Resident's risk of complications from indwelling catheter will be minimized with interventions. Observation on 11/06/24 at 8:35 a.m. reflected CNA A and CNA B did not completely close the privacy curtains while they provided catheter care for Resident #46, exposing the resident who could be seen from the room's door. Further observation revealed other staff members were in the room providing care for Resident 46's roommate. During an interview with CNA A and CNA B on 11/06/2024 at 8:55 a.m., they verbally confirmed the privacy curtains was not completely closed while they provided care for Resident #46, but it should have been. They stated she received resident rights training within the year. (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

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 11/06/2024

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 11/06/2024 at 12:00 p.m., the DON stated privacy must be provided during nursing care and Resident #46's privacy curtains should have been closed completely. She stated the staff had received training on resident rights within the year and the training was provided by the DON. They also check the staff skills annually and as needed. Review of the facility's policy titled Dignity, undated, reflected, Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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NAME OF PROVIDER OR SUPPLIER: Meridian Care Monte Vista		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36232 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and time frames to meet residents' mental, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and to ensure that the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including the right to refuse treatment for 1 of 8 residents (Resident #56) reviewed for care plans. Resident #56's cognitive communication deficit was not addressed in his comprehensive care plan. This failure could affect residents who have care areas not addressed by the care plan by not having their needs met and putting them at risk of not receiving appropriate care. The findings included: Record review of Resident #56's electronic face sheet dated 11/03/2024 indicated he was a [AGE] year old male admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction (weakness or paralysis on one side of the body that can occur after a cerebral infarction, a type of stroke that happens when blood flow to the brain is reduced or blocked), major depressive disorder (a serious mood disorder that affects how a person feels, thinks, and acts) and aphasia following cerebral infarction (a language disorder that can occur after a stroke that impairs the expression and understanding of language as well as reading and writing). The aphasia was classified as acute neurologic and a secondary diagnosis. Record review of Resident #56's admission MDS assessment with an ARD of 08/26/2024 revealed the resident had a BIMS of 11, indicating he had moderately impaired cognition. In Section I of this MDS, Active Diagnoses, Neurological, I4300, Aphasia was marked as a diagnosis. Record review of Resident #56's admission nursing assessment dated , 08/26/2024, indicated in section 18. Verbally the resident's speech was Dysphasic (dysphasic speech is a language disorder that affects a person's ability to understand or produce speech. It is also known as aphasia). Record review of a physician's progress note dated 09/25/2024 revealed the resident was, A [AGE] year-old male with a past medical history of CVA (02/2021) with expressive aphasia and residual left-sided weakness. Record review of Resident #56's comprehensive care plan, dated 08/26/2024, revealed there was no focus section addressing the resident's communication deficit. Observation on 11/05/2024 at 10:45 AM revealed a colored laminated communication card on Resident #56's nightstand. The card featured sections the resident could point to indicating what he wanted, liked, wanted to see, how he felt, levels of pain, the alphabet, and numbers. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An attempted interview on 11/05/2024 at 10:46 AM with Resident #56 revealed the resident's verbal communication was not clear. The resident had difficulty forming words to express his thoughts. When asked if he used the card on the nightstand to communicate with the staff, Resident #56 nodded his head. During an interview on 11/05/2024 at 2:22 PM, MDS LVN E stated Resident #56's communication was not clear, his communication deficit was not in his comprehensive care plan and should have been a focus area in the care plan. She was responsible for care plans. She could not explain why the communication deficit was not there. If the resident's communication deficit were not in his care plan, staff would not know to use other means of communication to meet his needs. During an interview on 11/05/2024 at 3:05 PM, the DON stated Resident #56 does not communicate clearly and his communication impairment should have been reflected in his comprehensive care plan. It was important the care plan reflect all the resident's conditions to ensure his needs are met by the staff. The MDS LVN is responsible for updating care plans. During an interview on 11/06/2024 at 2:30 PM, the Administrator stated Resident #56's communication card had been purchased from an on-line retailer. He was able to make his needs known to the staff but had a communication deficit that should have been noted in his comprehensive care plan. Record review of the facility's policy Care Plans, Comprehensive Person-Centered, revised March 2022, revealed: A comprehensive, person-centered care that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change), and no more than 21 days after admission. 3. The care plan is derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 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: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (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. C. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41651 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 (Resident #8) of 18 reviewed for environment, in that: Resident #8's bathroom contained potentially hazardous materials. This deficient practice could result in residents, staff, and/or the public coming into contact with potentially hazardous materials. The findings were: Record review of Resident #8's face sheet, dated 11/06/2024, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Unspecified Dementia Moderate with Psychotic Symptoms, Legal Blindness as Defined in USA, and Anxiety Disorder. Record review of Resident #8's quarterly MDS, dated [DATE], revealed a BIMS score of 0 which indicated severe cognitive impairment. Record review of Resident #8's care plan, undated, revealed [Resident #8] has delusions, hallucinations, auditory or visual related to dementia or other psychiatric disorder. [Resident #8] has potential for injury due to unqualified visual loss, right eye, glaucoma, cataracts, and has a diagnosis for legally blind. Observation on 11/03/2024 at 9:30 a.m. revealed cleaning supplies were stored behind a shower curtain in Resident #8's bathroom. Further observation revealed the supplies were each labeled with hazard warnings including: *Two containers of disinfecting spray, 19 ounces each, with warning label, hazardous to humans, may cause eye irritation, avoid contact with eyes and skin. *One container of isopropyl alcohol with warning label, warning flammable. *One container of bleach, 16 ounce, with warning label, danger keep out of reach of children, corrosive, causes irreversible eye damage and skin burns. *Two containers multipurpose cleaner, 56 ounces each, with warning label, may irritate eyes. *One container germicidal alcohol wipes, 160 wipes, with warning label, keep out of reach of children, hazardous to humans. *Two containers of bleach gel, 30 ounces each, with warning label, warning eye and skin irritant, not recommended for use by persons with heart conditions or chronic respiratory problems. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with RN D on 11/04/2024 at 11:25 a.m., RN D confirmed the above listed cleaning supplies were present in Resident #8's bathroom and should not have been. RN D confirmed that Resident #8 was legally blind, had a diagnosis of dementia, and that it was unsafe for her to have cleaning supplies within reach. During an interview with the DON on 11/05/2024 at 2:50 p.m., the DON stated cleaning supplies should not be present in resident rooms so that residents do not come into contact with potentially hazardous materials. The DON stated that Resident #8's family member cleans her room and likely brought the supplies. The DON stated she would remove the items from Resident #8's room and remind the resident and her family not to bring potentially hazardous materials into the facility. Record review of the facility policy, Homelike Environment, dated February 2021, revealed, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41651 Based on interview and record review, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 (Resident #48) of 18 residents reviewed, in that: Resident #48 displayed signs and symptoms of depression and was not offered mental health services. This deficient practice could place residents with mental health concerns at risk of diminished psychosocial well-being. The findings were: Record review of Resident #48's face sheet, dated 11/06/2024, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Malignant Neoplasm of Overlapping Sites of Right Bronchus and Lung, Type 2 Diabetes Mellitus, and Unspecified Dementia. Record review of Resident #48's quarterly MDS, dated [DATE], revealed a BIMS score of 9 which suggested moderate cognitive impairment. Further review revealed the resident responded affirmatively when asked if felt down, depressed, or hopeless. Record review of Resident #48's care plan, undated, revealed, adjustment: lifestyle change resulting from admission .episodes of insomnia .risk for excessive weakness, tiredness, weight loss, and pain [related to] diagnosis of lung cancer. I am receiving chemotherapy as ordered by my oncologist. Record review of Resident #48's clinical record revealed a progress note dated 04/09/2024, [Resident #48] reports episodes of depression, tiredness and poor concentration . Further review revealed a progress note dated 05/07/2024, [Resident #48] reports episodes of depression, poor sleep, tiredness and poor concentration . feeling isolated because he would prefer to be home. Further review revealed a progress note dated 07/09/2024, [Resident #48] reports episodes of depression, poor sleep, tiredness and poor concentration . He reports mild depression due to diagnosis of cancer. [Resident #48] spoke of feeling lonesome . Further review revealed a progress note dated 10/08/2024, [Resident #48] reports infrequent episodes of depression and feelings of isolation. [Resident #48 stated] 'I have no place to go. I feel like a prisoner here. During an interview with Resident #48 on 11/03/2024 at 9:42 a.m., Resident #48 stated he did not know why he resided at the facility, stated I am lonely, and I feel isolated and stated he felt like a prisoner. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #48's clinical record as of 11/06/2024 revealed no referral to mental health services. During an interview with the DON on 11/05/2024 at 2:35 p.m., the DON stated she did not know why Resident #48 had not been referred to mental health services and stated she was surprised it had not been done. The DON confirmed that Resident #48 had expressed feelings of depression and isolation and should have been referred to mental health services for psychosocial care and support. During an interview with the [NAME] on 11/05/2024 at 3:39 p.m., the DON stated a referral to mental health services had been initiated for Resident #48. Record review of the facility policy, Behavioral Health Services, revised February 2019, revealed, The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788 Based on observation, interview, and record review, the facility failed to ensure all drugs and biological were stored in locked compartments for 1 of 3 medication carts (Hall 200 Medication Cart) reviewed for storage, in that: During medications administration, RN C left Hall 200 Medication cart unlocked on 1 occasion. This deficient practice could place residents at risk of misappropriation of medications or harm due to accidental ingestion of unprescribed medications. The findings were: Observation on 11/05/2024 at 9:25 a.m. revealed RN C was administering medications to residents. RN C was seen entering room [ROOM NUMBER] and closed the door. The medication cart was left unlocked and out of sight of RN C. Inside the unlocked cart were blister packs, bottles, and vials of medications for the residents. During an interview with RN C on 11/05/2024 at 9:30 a.m., RN C confirmed the medication cart was left unlocked while she was administering medications in the resident's room. RN C confirmed she knew she had to keep the cart locked and had forgotten. During an interview with the DON on 11/06/2024 at 12:00 p.m., the DON confirmed the medication cart should have been kept locked. The DON confirmed the nursing staff received training about drug diversion including keeping their cart locked at all times when not in use to prevent drug diversion. The DON revealed one possible outcome of drug diversion was the residents missing doses of medications. Review of Nurse proficiency checklist for RN C, dated 09/10/2024 revealed RN C passed proficiency for Medication Administration. Record review of the facility's policy titled, Security of Medication Cart,, undated, revealed, Medication carts must be securely locked at all times when out of the nurse's view.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36232 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen, in that: 1. The facility failed to store plastic storage containers to allow for air-drying in the dish room. 2. The facility failed to store, label and date a container of chopped beef brisket in the walk-in cooler. 3. The facility failed to store and label French fries in the reach-in freezer. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: 1. Observation on 11/03/2024 at 9:58 AM revealed three opaque plastic containers stacked on top each of each other on a plastic tray in the clean side of the dish machine. There was an air-drying net separating the bottom container from the tray. There was no separation between the containers to allow for air circulation and drops of moisture were visible inside and between all three containers. During an interview on 11/03/2024 at 10:00 AM, the FSD stated wet plastic containers should not have been stacked on top of each other. Each container should have been placed face-down on an air-drying net to prevent the potential accumulation of bacteria which could lead to food borne illness. Staff working in the dish room were trained on how to store clean but damp dishware. They were trained upon hire and periodically throughout there year. The facility had an adequate supply of air-drying nets. 2. Observation on 11/03/204 at 10:10 AM in the walk-in cooler revealed an opened 5-lb. container of chopped beef brisket. The container was approximately 1/3 full. There was a label with the date 10/17/24. During an interview on 11/03/2024 at 10:11 AM, the FSD stated the date on the container of brisket was the date it was received by the facility and stored in the cooler. It was not the date it was opened or the use-by date. The container should have been labeled with both the date it was opened and the use-by date. Staff storing opened food in the coolers were responsible for properly labeling and dating all food items in the cooler with the date opened and use-by date; failure to do so could cause proliferation of bacteria that could lead to food borne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation on 11/03/2024 at 10:13 AM in the reach-in freezer revealed a package of food shaped like a log, wrapped in brown paper, with plastic wrap loosely covering the brown paper. There was a label with the date 9/17/24 but no label indicating the contents of the package. The FSD unwrapped the package revealing loose French fries. During an interview on 11/03/2024 at 10:14 AM, the FSD stated the package of food should have been properly labeled with the name of the contents and sealed in a container or storage bag with a zipper lock. Failure to label food stored in the freezer could result in staff not utilizing food in a timely manner and failure to properly seal stored food may cause freezer burn and a deterioration in food quality. Record review of the facility's policy, Sanitization, 2001, revealed: I0. Food preparation equipment and utensils that are manually washed will be allowed to air dry whenever practical. Record review of the facility's policy, Refrigerators and Freezers, 2001, revealed: 7. All food shall be appropriately dated to ensure proper rotation by expiration dates. 'Received' dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. 'Use by' dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and 'use by' dates indicated once food is opened. Record review of the facility's policy, Food Storage, 2023, revealed: 12. Leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated. Leftover food must be used within 7 days or discarded as per the 2022 Federal Food Code. (Also see policy on Use of Leftovers later in this chapter.) Check state regulations as some states may allow shorter time frames for the use of leftovers. 14. Frozen Foods: c. All foods should be covered, labeled, and dated. All foods will be checked to assure that foods will be consumed by their use by dates or discarded. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed: 4-901.11 Equipment and Utensils, Air-Drying Required. Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 3-501.17 Ready-to-Eat/Time Temperature Control for Safety Food, Date Marking. (B) Except as specified in (E) - (G) of this section, refrigerated, ready-to-eat, time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.

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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 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. 36232 Based on observation, interview and record review, the facility failed a to dispose of garbage and refuse properly for 1 of 2 Dumpsters (Dumpster #1) reviewed for disposal of garbage. The facility failed to ensure the waste in Dumpster #1 was removed to allow the top lid to close, the dumpster had a drainage plug, and the area around the dumpster was free of trash and debris. These deficient practices could place residents at risk for exposure to germs and diseases carried by vermin and rodents. The findings were: Observation on 11/05/2024 at 10:37 AM revealed there was overflowing trash at the top of Dumpster #1, preventing the lid from closing and leaving a gap approximately 18 in length. Further observation revealed there was a drainage plug missing on the right side of the dumpster, and there was trash and debris on the ground on the right side and back of Dumpster #1 that included plastic bags, an empty cardboard case of soda, a plastic glove, empty water bottle and cigarette butt. During an interview 11/05/2024 at 10:38 AM, the FSD stated trash was usually picked up twice a week. They had recently replaced Dumpster #1. The previous dumpster had a drainage plug. During an interview on 11/05/2024 at 10:42 AM, the Maintenance Director stated Dumpster #1 was missing a drain plug and he would get a new one. A drain plug was important was to prevent stray animals from getting into the dumpster and potentially spreading disease. The area was cleaned regularly, and he was surprised by the presence of debris surrounding the dumpster. Record review of the facility's policy, Waste Disposal, 2023, revealed: 2. Containers will be emptied as often as necessary throughout the day and at the end of each day. Trash bags will be sealed prior to removing them from the facility. Trash will be deposited into a sealed container outside the premises. Record review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 5-501.113 Covering Receptacles. Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered: (B) With tight-fitting lids or doors if kept outside the food establishment. 5-501.114 Using Drain Plugs. Drains in receptacles and waste handling units for refuse, recyclables, and returnables shall have drain plugs in place.

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 11/06/2024
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34788 Based on observation, interview, and record review, the facility failed to maintain an Infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 3 of 9 residents (Residents #162, #4, and #46) reviewed for infection control, in that: 1. RN D did not sanitize the blood pressure cuff between Resident #162 and Resident #4. 2. CNA A and CNA B did not wear a gown while providing care to Resident #46 who had been place on enhanced barrier precautions. These deficient practices could place residents at-risk for infection due to improper care practices. The findings include: 1. Observation on 11/05/24 at 9:54 a.m. revealed RN D was seen returning to his medication cart with a blood pressure cuff in hand after measuring Resident #4's blood pressure. He placed the blood pressure cuff on the medication cart and documented the blood pressure he had just taken. He, then, went to Resident #162 to take his blood pressure with the same blood pressure cuff without sanitizing the cuff. During an interview with RN D on 11/05/2024 at 10:09 a.m., RN D confirmed he had taken two blood pressures on two different residents with the same cuff and confirmed he did not sanitize the cuff between the residents. He revealed it could be a risk for cross contamination for the residents. He confirmed receiving training for infection control within the year. During an interview on 11/06/2024 at 12:00 p.m., the DON verbally confirmed the RN should have sanitized the blood pressure/pulse cuff in between the residents to avoid cross contamination. The DON revealed infection control training was provided to the staff multiple times a year. The DON revealed the staff's skills were checked annually. The DON further stated the ADONs did spot check of the staff for skills and infection control knowledge. Review of facility policy, titled Cleaning and disinfection of resident -care equipment, undated, revealed Reusable resident care equipment is decontaminated and/or sterilized between residents according to manufacturers' instructions. 2. Record review of Resident #46's face sheet, dated 11/06/2024, reflected an admitted [DATE] with diagnoses which included: Dysphagia (difficulty swallowing), Type 2 diabetes mellitus (high level of sugar in the blood), Cerebral palsy (group of movement disorders that appear in early childhood) and, Spina bifida (birth defect in which there is incomplete closing of the spine). Record review of Resident #46's Admission MDS assessment, dated 10/20/2024, reflected the resident had memory problems and was severely cognitively impaired. Resident #46 was dependent for his activities of daily living, had an indwelling catheter and, was always incontinent of bowel. (continued on next page)

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 11/06/2024
NAME OF PROVIDER OR SUPPLIER Meridian Care Monte Vista		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #46's care plan, dated 10/14/2024, reflected a problem of I require Enhanced Barrier Precautions., with a goal of Staff will adhere to my Enhanced Barrier Precautions status through the review period. Observation on 11/06/2024 8:35 a.m., revealed while providing catheter care for Resident #46, CNA A and CNA B did not don a gown. (resident is on enhanced barrier precautions). During an interview on 11/06/2024 at 8:55 a.m., CNA A and CNA B confirmed they did not put a gown on. They did not know the resident was on enhanced barrier precautions despite the signage on the wall next to the door. They confirmed receiving training for infection control within the year. During an interview on 11/06/2024 at 12:00 p.m., the DON confirmed a gown must be worn while providing care for a resident on enhanced barrier precautions to prevent cross contamination. The DON confirmed training on infection control, include enhanced barrier precaution, was provided at least annually by the DON and ADON and skills were checked at least annually. The DON revealed they had trained the staff on enhanced barrier precaution in the last month. Review of facility policy, titled Enhanced barrier precautions, undated, revealed, EBPs(enhanced barrier precautions employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room).