| 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 | 02/13/2026 |

| 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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure a resident's responsible party was informed in advance of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose alternative options is he or she preferred for 2 of 5 (Residents #52 and #4) residents reviewed for resident rights. The facility failed to notify and obtain consent from Resident #52 or her RP to administer buspirone (used to treat anxiety) and failed to adequately disclose potential side effects or complete all portions of the consents including physician diagnostic criteria and signature for diazepam (a benzodiazepine used to treat anxiety) and Lexapro (antidepressant). 2. The facility failed to notify and obtain consent from Resident #4 to administer Atarax (medication that caused sedation) and failed to adequately disclose potential side effectors or complete all portions of the consent including physician diagnostic criteria and signature for duloxetine (antidepressant). This failure could affect residents and/or responsible parties by placing them at risk for not being fully informed of the treatment and/or protentional risks of treatment. The findings included:1. Record review of Resident #52's face sheet dated 2/12/2026 revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included: amyotrophic lateral sclerosis (progressive neurodegenerative disease that affects nerve cells in the brain and spinal cord, leading to muscle weakness and atrophy), depression and anxiety disorder. Record review of Resident #52's significant change in status MDS assessment dated [DATE] revealed a BIMS score of 15 which indicated she was cognitively intact. Her functional status was listed as completely dependent on staff for all movement and all care. The assessment indicated Resident #52 was taking multiple medications listed a high-risk class drugs including antianxiety and antidepressant medications. Record review of Resident #52's Care Plan last revised 12/22/2025 revealed she had a plan of care for medication related to depression and anxiety which included side effect monitoring and behavior monitoring. Record review of Resident #52's Order Summary for February 2026 revealed the following medications:1. buspirone tablet 7.5 mg, give one tablet two times a day related to anxiety disorder with a start date of 12/12/2025. 2. diazepam tablet 5 mg, give 0.5 tablet one time a day for anxiety related to anxiety disorder with a start date of 2/5/20263. Lexapro 20 mg tablet, give one abet one time a day replated to anxiety and depression with a start date of 1/29/2026 Record review of Resident #52's consents for psychotropic medications revealed:There was no consent for buspirone in the resident's medical record. The consent for diazepam dated 1/22/2026 on form 3713 was incomplete. Information by the provider for length of time treating the patient was blank. The psychiatric condition or maladaptive behavior was left blank. The diagnoses based on diagnosis criteria and assessment indicated antianxiety without any additional information. Medication dose and frequency was left blank. The side effects and risk of proposed treatment had a statement that stated benefits outweigh the risks without listing the possible side effects of the medication. The document had not been signed by the physician or the Medical Director. The form indicated verbal consent was obtained by the RP. The consent for Lexapro dated 12/03/2020 on form 3713 which was incomplete. Information by the provider for length of time treating the patient was blank. The psychiatric condition or maladaptive behavior was left blank. The diagnoses based on diagnosis criteria and assessment (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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | indicated depression without any additional information. Medication dose and frequency was left blank. The side effects and risk of proposed treatment had a statement that stated benefits outweigh the risks without listing the possible side effects of the medication. The document had not been signed by the physician or the Medical Director. The form indicated verbal consent was obtained by the RP. During an interview on 2/12/2025 at approximately 3:40 p.m., Resident #52 was unable to answer whether or not she received information about her medication. She indicated her family member may have received the information. During an interview on 2/12/2026 at 4:00 p.m., Resident #52's RP (family member) stated she was called twice for consents for anxiety but did not remember the name of the medications. She stated she was not told of any potential side effects. She stated a nurse (unknown name) just told her the resident needed the medication and she agreed. 2. Record review of Resident #4's face sheet dated 2/12/2026 revealed a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses which included: moderate recurrent major depressive disorder, generalized anxiety disorder, and cyclothymic disorder (mood disorder with fluctuating highs/mania and lows/depression). Record review of Resident #4's quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 which indicated she was cognitively intact. Her functional status was maximal dependance on staff for movement and total dependance on staff for bodily hygiene. The MDS assessment indicated Resident #4 was taking antidepressant, medications. Record review of Resident #4's Care Plan last revised 12/08/2025 revealed she was taking antidepressant medications with an intervention which included: Assure consent is gen for administration of antidepressant. The care plan revealed she was taking antianxiety medication including buspirone and staff should assess for behavior manifested and notify MD. The care plan indicated the resident was receiving Atarax per MD orders for itching and refusal to shower (behavior). Record review of Resident #4's Order Summary for February 2026 revealed: Atarax (hydroxyzine) 10 mg, give one tablet by mouth every 8 hours as needed for itching with a start date of 1/15/2026. Duloxetine delayed release capsules 60 mg, give one capsule one time a day for depression with a start date of 1/15/2026. Record review of Resident #4's physician order for Atarax 10 (hydroxyzine) 10 mg in PCC had the following staff alert and drug protocol on this order: Clinical Reviews: Antianxiety Agents Notes: Must have consent for medication .This class of medication requires a consent . Record review of Resident #4's consents for treatment revealed: No consents for the use of Atarax were found in the resident's medical record. The consent for duloxetine dated 11/17/2025 on form 3713 was incomplete. Information by the provider for length of time treating the patient was blank. The psychiatric condition or maladaptive behavior was left blank. The diagnoses based on diagnosis criteria and assessment indicated major depressive disorder without any additional information or assessment. Medication dose and frequency was left blank. The side effects and risk of proposed treatment had a statement that stated benefits outweigh the risks without listing the possible side effects of the medication. The document had not been signed by the physician or the Medical Director. The form had the signature of the resident. During an interview on 2/12/2026 at approximately 3:48 p.m., Resident #4 stated she did not know if she had received information about her medication treatments. During an interview on 2/12/2026 at 4:21 p.m., LVN F stated consents for psychotropic medications were obtained when a new order was received by the physician. She stated it was typically the nurse who received the order's responsibility. LVN F stated they would tell the resident to ensure they were in agreement with the treatment and obtain consent from the RP. She stated if the resident was unable to sign, such as Resident #52, they would get signatures or telephone consent from the RP. LVN F stated two nurses were required to confirm telephone consent. She stated after the consents were obtained, she would make a copy of the consent and give one to the DON and one to medical records. LVN F stated ADON E and management were responsible for obtaining the physicians signature and consent because they were the ones making rounds with the physicians. LVN F stated she was the nurse responsible for Resident #52's diazepam consent. She stated there was only one nurse as a witness for the telephone consent. She stated she could not<br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | remember who else verified the RP gave consent. LVN F stated the consents for Resident #52's diazepam and Lexapro and Resident #4's duloxetine were missing most of the information. LVN F stated the DON gave the nurses instructions on how to fill out the forms. She stated the forms were prefilled in and she just obtained the actual consent. She stated she did not write anything else on the forms. LVN F stated the DON's signature was on Resident #52's Lexapro consent form as having completed the form which was incomplete. She stated she did not know who was responsible for completing Resident #4's consents or why they were missing and incomplete. During an interview on 2/12/2026 at 4:32 p.m., ADON E stated acknowledgement that the existing consents for Residents #52 and #4 were missing documentation and physician signatures. ADON E stated a few days ago (date unknown) she reviewed the consents for completeness and agreed they were not complete. She stated she was unaware of missing consents. ADON E stated up until a few days ago it was not part of her job duties and the DON was responsible. ADON E stated consents should be obtained for psychotropic medications including antipsychotics, hypnotics and antianxiety medication. She stated a consent for Atarax was not needed for Resident #4 because the medication was prescribed off label for itching and was not as a psychotropic medication. During an interview on 2/13/2026 at 9:42 a.m., the DON stated ADON E was responsible for monitoring psychotropic consents. She stated the charge nurses were responsible for obtaining the consents. The DON stated everything stops in her office (meaning she has final oversight). The DON stated they did some audits on consents but could not remember the details because she was consumed with the challenge of finding some things. She stated the ADONs should be double checking the consents for accuracy. The DON stated treatments were discussed during morning meetings. She stated the process was the nurses got the consents, the ADONs double check and she validates. The DON stated Atarax, even used off label should still get a consent. The DON stated it was important to obtain consent to treat and administer psychotropic medications so the family and resident were aware of the medication and so they could monitor outcomes. Record review of a Texas Health and Human Services list of psychotropic medications dated January 2025 listed: Atarax (hydroxyzine), diazepam and buspirone in the class of medications of anxiolytics/sedatives/hypnotics. Duloxetine and Lexapro were listed as antidepressants. Record review of the facility policy, titled Resident Rights dated February 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: p. be informed of, and participate in, his or her care planning and treatment. Record review of the facility policy, titled Antipsychotic Medication Use dated July 2022 revealed: 13. Residents (and/or resident representatives) will be informed of the recommendation, risks, benefits, purpose and potential adverse consequences of antipsychotic medication use. Residents (and/or representatives) may refuse medications of any kind. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, interview, and record review, the facility failed to ensure drugs and biological were stored in a manner that permitted only authorized personnel to have access to the keys for 1of 2 Medication Rooms (100 hall medication room) reviewed for pharmacy services. The facility failed to ensure 1 of 2 doors remained locked on the hallway medication room. This failure could place residents receiving medication at risk for access by unauthorized personal, visitors and residents. The findings included: During an observation on 2/11/2026 at 2:11 p.m., the medication room on the first floor 100 hallway was observed to have two doors. The door inside the nurse's station was locked. The door on the hallway was unlocked and was able to be opened. Inside the medication room, visible from the doorway were multiple over the counter medications, a medication refrigerator, a resident snack refrigerator and resident snacks. A cabinet on the bottom shelf with prescription medication that was visible through a crack was locked. There was no staff present in the hallway or at the nurse's station. During an interview on 2/11/2026 at 2:14 p.m., LVN H stated she was not aware the door on the hallway to the medication room was unlocked. She stated the door was supposed to be locked at all times. She stated the medication room had over the counter meds, insulin in the refrigerator and other prescription medications in the refrigerator. She stated the bottom locked shelf contained prescription medications for destruction. LVN H stated the snacks were meant for the residents. She stated residents were not allowed in the room, only staff with keys. She stated she had keys to the medication room. She stated only licensed staff held the keys. LVN H stated it was important for the medication room to remain locked because the room held medications and residents could get to them if left unlocked. During an interview on 02/11/2026 at 3:24 p.m., the DON stated she was not aware there was a second door that was being utilized to the 100-hallway med room. She stated the med room should remain locked at all times. She stated only licensed staff had keys and should have access to the room. The DON stated it was important because there were meds stored in the room that should have be accessed. Record review of the facility policy, titled Medication Labeling and Storage dated February 2023 revealed: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. 4. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, ) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 6 residents (Residents #3, #5 and#43) reviewed for infection control, in that: 1.On 02/12/2026, the Facility failed to ensure LVN A changed gloved and sanitize her hands after touching Resident #3's environment. 2. On 02/12/2026, the Facility failed to ensure RT C wore a gown while providing care for Resident #5 who was on Enhanced Barrier Precaution. 3.On 02/12/2026, the Facility failed to ensure LVN A used a disposable cloth under Resident #43's wound, during wound care, to prevent cross contamination. These deficient practices could place residents at-risk for infection due to improper care practices.The findings include: 1.Record review of Resident #3s face sheet, dated 02/13/2026 , revealed an admission date of 07/31/2025 and, a readmission date of 01/22/2026, with diagnoses that included: Dementia (decline in cognitive abilities), Bipolar disorder (Mental disorder characterized by periods of depression and periods of abnormally elevated mood), Chronic kidney disease (gradual loss of kidney function), Tracheostomy status (artificial opening into trachea allowing breathing), Gastrostomy status (opening through the abdominal wall into the stomach allowing feeding), Type 2 diabetes mellitus (high level of sugar in the blood) and, Hypertension (High blood pressure). Record review of Resident #3's significant change MDS assessment, dated 01/28/2026, revealed a BIMS score of 7, which indicated the resident's cognition was severely impaired, and was indicated to always be incontinent of bowel and bladder. Record review of Resident #3's care plan dated 02/02/2026, revealed a problem of requires Enhanced Barrier Precautions. and an intervention of Maintain Enhanced Barrier Precautions during high contact resident care activities (i.e., dressing, bathing/showering, transferring, providing hygiene, linen changes, peri care/changing briefs/toileting, chronic wound care, and all in-dwelling device care:tracheostomy, central lines, feeding tubes, urinary catheters Observation on 02/12/2026 at 01:02 p.m. revealed while providing incontinent care for Resident #3, LVN A touched the privacy curtain with her gloved hands and without changing her gloves or sanitizing her hands touched the resident's skin to start assisting CNA B with providing care. During an interview on 02/12/2026 at 1:16 p.m. with LVN A, she stated she did not think about the curtain being considered dirty and she should have changed her gloves and sanitized her hands to prevent cross contamination and infection for the resident. She stated she had received infection control training within the year. During an interview with the DON on 02/12/2026 at 3:15 p.m., she stated that staff should change their gloves and sanitize their hands after touching anything in the resident's proximity and before touching the resident and provide care. She stated training for infection control was provided at least annually by the DON and ADONs. Record review of facility's policy titled Standard precautions, dated September 2022, revealed, Hand hygiene is performed [ .] after contact with items in the resident's room. 2. Record review of Resident #5's face sheet, dated 02/12/2026 , revealed an admission date of 02/19/2025 and, a readmission date of 09/17/2025, with diagnoses that included: Anoxic brain damage(Brain injury caused by lack of oxygen), Tracheostomy status (artificial opening into trachea allowing breathing), Gastrostomy status (opening through the abdominal wall into the stomach allowing feeding), Type 1 diabetes mellitus (high level of sugar in the blood). Record review of Resident #5's Annual MDS, dated [DATE], revealed Resident #5 was nonverbal and her cognition was severely impaired. She had a tracheostomy. Record review of Resident #5's care plan dated 12/19/2025, revealed a problem of requires Enhanced Barrier Precautions. and an intervention of Maintain Enhanced Barrier Precautions during high contact resident care activities (i.e., dressing, bathing/showering, transferring, providing hygiene, linen changes, peri care/changing briefs/toileting, chronic wound care, and all in-dwelling device care:tracheostomy, central lines, feeding tubes, urinary catheters Observation on 02/12/2026 at 10<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | a.m., RT C did not put on a gown before starting to provide Tracheostomy care for Resident #5 During an interview on 02/12/2026 at, 10:13 a.m., RT C stated he knew the resident was on Enhanced Barrier Precaution, but he forgot to put a gown on. He stated he did not know why he had forgotten. He confirmed it was a risk of contamination for the resident. He stated he received infection control training within a year During an interview with the DON on 02/12/2026 at 10:30 a.m., the DON stated that a resident with a tracheostomy was on Enhanced Barrier Precaution and the staff should wear gown and gloves while providing care. She stated the staff were provided with infection control and Enhanced Barrier Precaution training. The training was provided by the DON and the DONs. Record review of facility's policy titled Standard precautions, dated September 2022, revealed, Gowns are worn for direct resident contact [ .]. 3. Record review of Resident #43's face sheet, dated 02/13/2026 , revealed an admission date of 08/04/2025 and, a readmission date of 12/11/2025, with diagnoses that included: Chronic kidney disease (gradual loss of kidney function), Tracheostomy status (artificial opening into trachea allowing breathing), Type 2 diabetes mellitus (high level of sugar in the blood) and, Open wound of back wall of thorax (wound in the middle of the back penetrating in the chest cavity). Record review of Resident #43's significant change MDS, dated [DATE], revealed a BIMS score of 15, which indicated the resident's cognition was intact. The resident was coded as having surgical wounds. Record review of Resident #43's care plan dated 11/20/2025, revealed a problem of is at risk for skin breakdown and is at risk for new pressureulcers r/t limited mobility, [ .] has multiple skin impairments that require treatments and an intervention of Refer to UT Health Infectious Disease related to long term antibiotic management for infection suppression at site of dehisced post-surgical scar. Observation on 02/12/2026 1:18 p.m revealed while providing wound care for Resident #43, LVN A did not place a disposable cloth next to the resident under the wound. After the wound was cleaned, the wound and its surrounding skin was close to the surface of the air mattress. During an interview on 02/12/2026 at 1:35 p.m. with LVN A, she stated she did not use a disposable cloth, but the wound did not touch the mattress after being cleaned. During an interview with the DON on 02/12/2026 at 3:15 p.m., she stated that staff should place a disposable cloth under the wound to prevent potential contamination with linen or mattress under the resident. She stated infection control training was provided annually and staff skills were checked annually. Record review of facility's policy titled Wound care, dated October 2010, revealed, Position resident. Place a disposable cloth next to the resident (under the wound) to serve as a barrier [ .]. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 1 of 2 units (unit 200) reviewed for physical environment, in that: The Facility failed to ensure that hazardous products, such as disinfecting wipes, were kept out of reach of the residents. These deficient practices could place residents and staff at-risk for injury.The findings were: Observation on 02/12/2026 at 1:18 p.m., revealed while providing wound care for a resident, LVN A used sanitizing wipes to clean a side table. After sanitizing the side table, she left the wipes container on top of her cart and went in the room to provide care. She closed the door and lost line of sight with the wipes. The wipes were left on top of the cart for the length of the care, from 1:18 p.m. to 1:25 p.m. Observation on 02/12/2026 at 1:25 p.m., revealed the wipes container had a caution label for causes moderate eye irritation, avoid contact with eyes [ .] physical or chemical hazards, flammable. During an interview with LVN A on 02/12/2026 at 1:25 p.m., the LVN Stated she had left the wipes on top of her cart after entering the room. She stated she did not know the wipes should be kept in her cart and away from the residents. During an interview with the DON on 02/12/2026 at 3:15 p.m., the DON stated hazardous product should be kept under lock when not used to prevent resident accessing them and harming themselves. She stated the staff was provided training annually about keeping dangerous products under lock. She confirmed residents with dementia and impaired cognition were on the second floor and some residents could use their wheelchair independently. Record review of facility's policy titled Cleaning and disinfection of environmental surfaces, dated August 2019, revealed Manufacturers' instructions will be followed for proper use of disinfecting products including [ .] storage. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care with 48 hours of the resident's admission for 1 (Resident #68) of 1 residents reviewed for baseline care plans, in that: Resident #68 did not have a baseline care plan. This deficient practice could result in improper treatment.The findings were:<br>Record review of Resident #68's facesheet, dated 02/12/2026, revealed the resident was admitted to the facility on [DATE] with diagnoses including Essential (Primary) Hypertension, Obstructive Sleep Apnea, and Heart Disease. Record review of Resident #68's discharge MDS, dated [DATE], revealed a BIMS score of 15 which indicated intact cognition. Record review of Resident #68's full clinical record revealed he resided at the facility from 11/13/2025 to 11/18/2025 and no baseline care plan was developed for him during his admission. During an interview with ADON J on 02/12/2026 at 5:00 p.m., ADON J confirmed that no baseline care plan had been developed for Resident #68 during his tenure at the facility, stated she did not know why it had not been completed, and stated it should have been. ADON J stated the baseline care plan includes information necessary for staff to care for the resident. Record review of the facility policy, Care Plans - Baseline, revised December 2016, revealed, A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 5 residents (Residents #5) reviewed for care plans: The facility failed to ensure Resident #5 comprehensive care plan included a plan for anemia with goals and interventions to address her low hemoglobin and hematocrit (which could be symptoms of anemia). This deficient practice could cause incomplete information to be given to staff responsible for care to the residents and place residents at risk of receiving improper care and services. The findings included:Record review of Resident #5's face sheet dated 2/13/2026 revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included: anoxic brain damage, type 1 diabetes mellitus and dependence on supplemental oxygen. Record review of Resident #5's annual MDS assessment dated [DATE] revealed a BIMS score that could not be obtained with both short term and long-term memory problems and indicated a severe cognitive impairment. The assessment indicated the resident was dependent on staff for care and had a PEG tube. Record review of Resident #5's Care Plan last revised on 12/19/2025 revealed it did not address her anemia or appropriate interventions. Record review of Resident #5's physician order dated 9/17/2026 revealed an order for ferrous sulfate give 5 ml of ferrous sulfate solution 300 mg/5 ml (60 Fe) via G-tube (feeding tube) two times a day for anemia. Record review of Resident #5's lab work dated 1/12/2026 revealed low hemoglobin at 9.6 (normal 11.5-15.5) and hematocrit 32.7 (normal 34.0-45.0) which could be indicitive of anemia. Record review of Resident #5's lab work dated 2/02/2026 revealed low hemoglobin at 9.8 and hematocrit at 33.1 which could be indicative of anemia. During an interview on 2/13/2026 at 12:10 p.m., the MDS Coordinator stated the care plan for Resident #5 did not contain a plan of care for anemia or the use of iron supplementation. She stated ideally the care plan should address the use of iron supplementation for the treatment of anemia. The MDS Coordinator stated she reviewed medications and lab work, and they talked about residents in morning meetings. She stated if it was not discussed in morning meeting she was unaware of it. She stated she does not review labs on a normal basis unless something was brought to her attention. The MDS Coordinator stated the facility communicated as a team and she would expect something like this to have been brought up. She stated the nurses could not alter care plans. She stated she was responsible for most of the review and update of the resident care plans. The MDS Coordinator stated it was important to include iron supplementation and anemia on the care plan so the nurses would know that the physician orders jived (coordinated) with the care plan. During an interview on 2/13/2026 at 12:22 p.m., the DON stated the care plans were interdisciplinary. She stated an RN was required to open a new care area and then the team decided what was included. The DON stated she was an RN, one of the ADON's was an RN and they also had RNs on the nursing staff. She stated the MDS Coordinator was an LVN and could edit based on team input. The DON stated accurate complete comprehensive care plans were important for the resident and so the staff could evaluate the nursing process. Record review of the facility policy, titled Care Plans, Comprehensive Person-Centered dated March 2022 revealed: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. |

| 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 | 02/13/2026 |

| 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.

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|---|---|
| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure incontinent care was provided in accordance with appropriate treatment and service practices to prevent urinary tract infections and to restore continence to the extent possible for 1 of 2 residents (Residents #3) reviewed for for quality of care, in that: The facility failed to ensure, while providing incontinent care for Resident #3, CNA B did not make multiple passes with the same wipe to clean Resident #3, she spread the resident's labia and cleaned Resident #3's anal area. This deficient practice could place residents at-risk for infection and skin break down due to improper care practices.The findings were: Record review of Resident #3s face sheet, dated 02/13/2026 , revealed an admission date of 07/31/2025 and, a readmission date of 01/22/2026, with diagnoses that included: Dementia (decline in cognitive abilities), Bipolar disorder (Mental disorder characterized by periods of depression and periods of abnormally elevated mood), Chronic kidney disease (gradual loss of kidney function), Tracheostomy status (artificial opening into trachea allowing breathing), Gastrostomy status (opening through the abdominal wall into the stomach allowing feeding), Type 2 diabetes mellitus (high level of sugar in the blood) and, Hypertension (High blood pressure). Record review of Resident #3's significant change MDS, dated [DATE], revealed a BIMS score of 7, which indicated the resident's cognition was severely impaired, and was indicated to always be incontinent of bowel and bladder. Record review of Resident #3's care plan dated 02/02/2026, revealed a problem of is at risk for skin integrity r/t (related to) loss incontinence of bowel and bladder and an intervention of Provide peri-care after each incontinent episode Observation on 02/12/2026 at 01:02 p.m. revealed while providing incontinent care for Resident #3, CNA B did not change wipe between across the abdomen and the right-side groin. CNA B did not separate Resident #3's labia and did not clean Resident #3's anal area. During an interview on 02/12/2026 at 1:16 p.m. with CNA B, she stated she did not change the wipe between the abdomen and right groin. She also stated she should have cleaned between Resident #3's labia and should have cleaned the resident's anal area. She stated she thought she could use the same wipe if she was folding them. She stated she forgot to separate the labia and did not know she should clean deeper between the buttocks. She stated she received training for infection control and incontinent care at least annually. During an interview with the DON on 02/12/2026 at 3:15 p.m., she stated that staff should not do multiple passes with the same wipe during incontinent care. The staff should separate the female resident's labia when cleaning and should clean the anal area. She stated appropriate incontinent care was important to prevent infection for the residents. She stated training was provided for the staff, at least annually and, their skills were checked every year by the DON and ADON. Record review of facility's policy titled Perineal care, dated February 2018, revealed, Separate labia [ .] wash the rectal area thoroughly. |

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|---|---|---|---|
| | 455450 | A. Building<br>B. Wing | 02/13/2026 |

| 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.

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|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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 observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispending, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 8 residents (Resident #5) reviewed for pharmacy services. The facility failed to ensure Resident #5 received the correct dose of ferrous sulfate (iron supplement) on 3/11/2026 of 5 ml of 300 mg/5 ml (60 Fe) as prescribed by the physician. This failure could place residents at risk of receiving the correct dosage of medication and put them at risk for medication errors. The findings included: Record review of Resident #5's face sheet dated 2/13/2026 revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included: anoxic brain damage, type 1 diabetes mellitus and dependence on supplemental oxygen. Record review of Resident #5's annual MDS assessment dated [DATE] revealed a BIMS score that could not be obtained with both short term and long-term memory problems and indicated a severe cognitive impairment. The assessment indicated the resident was dependent on staff for care and had a PEG tube. Record review of Resident #5's Care Plan last revised on 12/19/2025 revealed it did not address anemia or the use of iron supplementation. Record review of Resident #5's physician order dated 9/17/2026 revealed an order for ferrous sulfate give 5 ml of ferrous sulfate solution 300 mg/5 ml (60 Fe) via G-tube (feeding tube) two times a day for anemia. During an observation on 2/11/2026 at 8:13 a.m., LVN G dispensed 5 ml of liquid ferrous sulfate 220 mg/5 ml solution and administered it to the resident via a feeding tube. During an interview on 2/11/1026 at 1:22 p.m., LVN G stated the bottle of ferrous sulfate used for the med pass was 220/ml instead of 300/5ml for Resident #5. He stated it was a medication error. He did not respond when asked for the process of administering medication and comparing labels to what was ordered. He stated it was what they had been giving the patient. During an interview on 2/11/2026 at 2:40 p.m., the DON stated medication should be dispensed and given as ordered by the physician. She stated the order should be verified against the medication label on hand and if there were any discrepancies the physician should be notified for clarification. The DON stated it was important, so the resident received the correct dosage of medication. Record review of the facility policy, titled Administering Medications dated April 2019 revealed: Medications are administered in a safe and timely manner, and as prescribed. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. |

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|---|---|---|---|
| | 455450 | A. Building<br>B. Wing | 02/13/2026 |

| 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.

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|---|---|
| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident was not given a psychotropic drug unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 1 of 5 residents (Resident #4) reviewed for unnecessary medications, in that: The facility failed to ensure Resident #4 psychotropic medication, Atarax was prescribed no longer than 14 days PRN. Resident #4 was ordered PRN Atarax (an antihistamine medication with sedative and hypnotic effects used to treat anxiety disorders) on 1/15/2026 without a stop date. This failure could place residents at risk of receiving unnecessary psychotropic medications. The findings included: Record review of Resident #4's face sheet dated 2/12/2026 revealed a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses which included: moderate recurrent major depressive disorder, generalized anxiety disorder, and cyclothymic disorder (mood disorder with fluctuating highs/mania and lows/depression). Record review of Resident #4's quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 which indicated she was cognitively intact. Her functional status was maximal dependance on staff for movement and total dependance on staff for bodily hygiene. Record review of Resident #4's Care Plan last revised 12/08/2025 revealed the resident was receiving Atarax per MD orders for itching and refusal to shower (behavior). Record review of Resident #4's Order Summary for February 2026 revealed: Atarax (hydroxyzine) 10 mg, give one tablet by mouth every 8 hours as needed for itching with a start date of 1/15/2026. Record review of Resident #4's physician order for Atarax 10 (hydroxyzine) 10 mg in PCC had the following staff alert and drug protocol on this order: Antianxiety Agents Notes: Must have consent for medication .This class of medication requires a consent, side effect and behavior monitoring. the end date was listed as indefinite. Record review of Resident #4's consents for treatment revealed: No consents for the use of Atarax were found in the resident's medical record. During an interview on 2/12/2026 at approximately 3:48 p.m., Resident #4 stated she did not know if she had received information about her medication treatments. During an interview on 2/12/2026 at 4:32 p.m., ADON E stated consents should be obtained for psychotropic medications including antipsychotics, hypnotics and antianxiety medication. She stated a consent for Atarax was not needed for Resident #4 because the medication was prescribed off label for itching and was not as a psychotropic medication and would not need a specific end date because it was used for itching and not as a psychotropic medication. She stated she was aware of the rule of 14-day limits for PRN psychotropics but was unsure how they applied because people had told her different things. During an interview on 2/13/2026 at 9:42 a.m., the DON stated the computer flagged psychotropics at 14 days. She stated the psychology group monitored psychotropic medications and communicated with the ADON on Fridays. She stated Atarax usage for Resident #4 was a conversation with the psychologist, the physician and the pharmacy. She stated it was important to limit its use in order to monitor outcomes and ensure it was serving the purpose (intended). Record review of a Texas Health and Human Services list of psychotropic medications dated January 2025 listed: Atarax (hydroxyzine), diazepam and buspirone in the class of medications of anxiolytics/sedatives/hypnotics. Duloxetine and Lexapro were listed as antidepressants. Record review of the facility policy, titled Antipsychotic Medication Use dated July 2022 revealed: 16. PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication and documented the rationale for continued use. The duration of the PRN order will be indicated in the order. |