STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675171	A. Building B. Wing	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Care	7181 Crestway Dr San Antonio, TX 78239

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on observations, interviews, and record review, the facility failed to maintain medical records, in accordance with accepted professional standards and practices, which were complete and accurately documented for 1 of 5 residents (Resident #1) reviewed for documentation. Resident #'1's electronic medical record did not contain complete and accurate documentation that the resident received three meals on 3/9/24 and 3/10/24. This failure could result in residents' records not accurately documenting delivery of meals, any assistance provided to the resident in consuming meals,; and could result in documentation not showing meal consumption, loss of weight and dehydration, and a diminished quality of life. The findings included: Record review of Resident #1's face sheet, dated 3/18/24, revealed, the resident was admitted on [DATE] with diagnoses that included: dystonia (neurological disease), HTN (hypertension), and contractures. The resident was a female at the of age 60. The RP was listed as: a family member. Record review of Resident#1's quarterly MDS assessment, dated 1/16/24, revealed: o BIMS Score was 15 (cognitively intact) o ADLs : incontinent of both bowel and bladder. Transfer was listed as total dependence (mechanical lift). Range of motion was impairment to upper and lower extremities. Section GG for feeding listed dependent for feeding. Record review of Resident# 1's Care Plan, undated, , revealed, the goals and interventions included: nutritional risk with the interventions of no added salt, regular texture, regular liquids, and double portions. The resident was listed as total dependence for eating. Record review of Resident#1's Physician's Orders, dated March 2024 read: NAS (No Added Salt) diet, REGULAR texture, REGULAR consistency .Double protein & veggies. Pt to have total assistance, sit upright at least 45 degrees, go slow, small bites and sips, alternate bites, and sips, remain upright s/p meal 45 mins. May have salads. (resident wants food cut up into bite size pieces by CNA) . (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's initial assessment on 10/10/2020 read: Resident was screened for PT/OT/ST due to exposure to Covid-19. She is total dependent with ADL . She is tolerating prescribed PO diet without difficulty. Record review of Resident #1's POC for nutrition task revealed: 3/9/24-no meals documented. 3/10/24-no meals documented. Record review of Resident#1's Nurse Note revealed: no information that Resident #1 refused to eat on 3/9/24 and 3/10/24. During an interview on 3/18/24 at 2:38 PM, LVN E stated: meals were missing for the date range 3/9/24 and 3/10/24 which were due to lack of documentation by the nurse aides [CNA B and CNA C]. LVN E stated that there were no notes that the resident refused to eat on 3/8/24 to 3/13/24. LVN E stated the resident was fed but not documented by the nurse aides. During an interview on 3/18/24 at 3:14 PM, RN E stated: she was the supervisor for the weekend of 3/9/24 and 3/10/24 when agency staff were present. RN E stated that on the evening of 3/9/24 the dinner trays were late. RN E stated the resident called her spouse and he brought her food. The facility tried to deliver the dinner meal and the spouse and resident refused the dinner meal. RN E stated the resident did receive her breakfast and lunch meal on 3/9/24 and it was not documented by agency staff [CNA B and CNA C]. RN E added on 3/10/24 the resident got all her meals but not documented by the nurse aides. RN E stated, I fed her on 3/10/24 the dinner meal RNE stated she did not document the feeding and did not check on the documentation of CNA A and CNA B. no one checked on documentation. During a joint interview with the administrator and the DON on 3/18/24 at 3:42 PM, the DON stated: Resident #1was fed on 3/9/24 and 3/10/24 but the agency staff and the weekend supervisor did not document it in the POC . The resident was fed late on 3/10/24 by RN E. The Administrator stated that no specific training was done for agency staff or weekend staff on documenting feeding or refusal to be fed in the medical record The DON added the resident was not neglected on feeding, but documentation was lacking for 3/9/24 and 3/10/24. The Administrator and the DON stated the failure of documentation could cause confusion as to whether the resident was fed. During an interview on 3/19/24 at 10:15 AM, the DON stated that per her discussion with the weekend charge nurse, LVN A, Resident #1 was assisted with feeding on 3/9/24 and 3/10/24. On 3/9/24, CNA B fed the resident breakfast, lunch, and dinner. Also, on 3/10/24 CNA C fed the resident breakfast, lunch and RN D fed the dinner meal on 3/10/24. The DON stated the nursing staff did not document in the medical record that the meals were fed. The DON stated that the staff except RN D were agency nurses not fully oriented to the facility's documentation methods for feeding residents. The DON added that lack of documentation could create concerns as to whether the resident was fed and lead to unfounded allegations. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 3/19/24 at 10:20 AM with LVN A, she stated that on 3/9/24 and 3/10/24 the resident was fed all three meals, but it was not documented in the POC because the aides did not have access to POC. LVN A added that no having access to POC could created misinformation as to whether residents were fed their meals. Record review of Resident #1's grievance dated 3/10/24 filed for the weekend of 3/9/24 revealed a family grievance of meals being late for Resident #1. Resolution: The DON called the family member and ensured the family member she would check on meal times for Resident #1 Grievance resolution revealed that RN E fed the dinner meal to the resident on 3/10/24. . Record review of facility's Charting and Documentation policy dated revised July 2027 read: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record . Record review of the facility's Charting Errors and/Omissions policy dated revised December 2006 read: Accurate medical records shall be maintained by the facility .