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	10/03/2024

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 interviews and record review, the facility failed to maintain medical records, in accordance with accepted professional standards and practices, that are complete; and accurately documented for 1 of 6 residents (Resident #1) reviewed for administration: The facility failed to ensure Resident #1's Nurse Note, dated 9/29/24 and authored by LVN A, documented the insertion of a suprapubic catheter (a surgically created tube that drains urine from the bladder through a small incision in the lower abdomen) and urine output. Also, LVN A stated she did not check and document catheter care on 9/29/24. This failure could result in residents receiving catheter care not receiving continuity of care and a diminished quality of life. The findings were: Record review of Resident #1's face sheet, dated, revealed an admitted [DATE] and discharged [DATE] to hospital with diagnoses that included: dissection of vertebral artery (surgery to the spine), bacterial infection, unspecified, neuromuscular dysfunction of bladder, and quadriplegia, unspecified. The resident was a male age 22. The RP was listed as self. Record review of Resident #1's quarterly MDS (minimum data set) assessment, dated 9/10/24, reflected: Resident #1'sBIMS (brief interview of mental status) Score was 15 (cognitively intact). Also, Resident #1 had a suprapubic catheter for urine output. Record review of Resident# 1's Care Plan, undated, reflected, the goal of catheter care and interventions included: change catheter per physician order, assess urine quantity, clarity, color, and odor. Record review of Resident #1's ER H&P dated 9/30/24 read: Chief Complaint .Gross hematuria (blood in the urine), Suprapubic cath malfunction. Record review of Resident#1's Physician' Orders, dated September 2024: reflected: CHANGE SUPRAPUBIC CATHETER + BAG as needed for occlusion (blockage) or leakage. (continued on next page)

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 TAR dated 10/30/24 reflected: flush of catheter was done [no order for flush] Record review of Resident #1's POC documentation urine output revealed: no documentation for urine output on 9/28/28; t Record review of Resident #1's Nurse Notes dated 9/29/24 reflected no documentation that the resident's suprapubic catheter had been changed by LVN A. Observation and interview on 10/01/24 at 2:25 PM, revealed Resident #1 was in the ER bed, alert and oriented to person, place, and time, and receiving IV antibiotics. His catheter was present. Resident had paralysis to his upper and lower body. The resident stated that his catheter was changed on Sunday (9/29/24) around 7:30 PM by LVN A. The resident added that on Monday (9/30/24) at 9 AM, LVN A told him that she changed the catheter bag and told him, I flushed it and it worked. During a telephone interview on 10/3/24 at 10:22 AM, the MD stated the suprapubic catheter was changed on (Sunday) 9/29/24, and he had no concerns about facility nurses performing suprapubic catheter insertions. The MD stated that Resident #1 had a history of UTIs and was mobile in his motorized scooter. During an interview on 10/2/24 at 5:02 PM, LVN A stated she changed the suprapubic catheter on 9/29/24 at 8:30 PM. LVN A stated, I advanced the catheter into the bladder and urine came out and then filled the balloon to stabilize the foley .a little urine came out .I forgot to document [in the clinical record]. The LVN stated she changed the catheter because the resident was wet and was leaking from his penis which meant the catheter was not working. LVN A again stated, .I checked the catheter bag around 8:30 PM and saw urine draining into the bag and not leaking from his penis .I did not document .it was a busy night .I again checked at 10 PM and the Foley was draining properly. LVN A stated she had competencies in suprapubic catheter insertion and documentation. During an interview 10/03/24 at 9:30 AM, the DON stated LVN A did perform a suprapubic insertion on Resident #1 on 9/29/24 and did not document. The DON stated that major events needed to be documented, and if another nurse was present, the documentation should have been done in the progress notes. The DON stated that during catheter care the nurse staff should document that output occurred or any abnormal findings. The DON stated that LVN E was present when LVN A inserted the suprapubic catheter but did not document the procedure in the nurse progress notes. The DON stated that LVN D, throughout the shift (10:00 PM to 6:00 AM), checked on Resident #1 and the resident had urine output. . 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.

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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** 34957 Based on observation, interview, and record review, the facility failed to establish and 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 diseases and infections, for 1 of 11 residents (Resident #2) reviewed for infection control, in that: The facility failed to ensure Resident #2's catheter bag was anchored on the bed rail and not lying on the floor. This failure could result in the spread of disease and expose residents with catheters to infections and a diminished quality life. The Findings were: Record review of Resident #2's face sheet, dated 10/02/24, reflected a [AGE] year-old female, with an admitted [DATE] and a re-admitted [DATE] with diagnoses that included: type 2 diabetes (primary), a history of UTI (urinary tract infection), and end stage renal disease. The RP was listed as self. Record review of Resident#2's admission MDS (minimum data set), dated 9/19/24, reflected: a BIMS (brief interview of mental status) score was 15. (Cognitively intact). Also, Resident #2 had a Suprapubic catheter, and was occasionally incontinent of bowel. Record review of Resident # 2's Care Plan was in progress as a new admission. Record review of Resident #2's Physician' Orders, dated October 2024, reflected: change catheter every 15th day of the month. Record review of Resident # 2's TAR (treatment administration record), dated October 2024, reflected, as ordered, the resident received treatment on 10/1/24 which included: urine output and monitored the suprapubic care shift evening and day. Observation and interview on 10/2/24 at 11:10 AM, revealed Resident #2 was in bed, alert and oriented to person, place, and time. Resident #2's catheter bag was on the floor , and no urine present in the bag. Further observation revealed the catheter bag was not anchored to the bed rail; and no urine was flowing into the bag. There was clear and yellow urine in the tubing. Bed position was at 45 degrees. There were no kinks in the tubing. The resident stated that morning staff said it is not their role to empty the catheter bag. The resident added that she had no issues with the emptying of the catheter bag by the evening or night shift. [Resident #2 was not asked about the catheter not anchored to the bed on the floor.] (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/2/24 at 11:25 AM, LVN F stated she observed Resident #2's catheter bag was on the floor, and it should not be on the floor because it could create an infection control issue. LVN F stated that nursing staff was responsible for checking on the anchoring of the bag. She had no explanation why the bag was on the floor and why the day shift did not check the placement of the bag. LVN F stated she was the charge nurse for the day shift that provided catheter care to Resident #2. During an interview on 10/2/24 at 11:30 AM, the DON stated she checked on Resident #2's catheter bag 10 minutes prior to the surveyor's interview with Resident #2 and the bag was anchored. She had no explanation why the bag was on the floor. The DON stated the bag on the floor presented an IC concern. Record review of facility's Catheter Care, Urinary policy revised September 2024 read: Be sure the catheter tubing and drainage bag are kept off the floor.