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	11/22/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview, and record review the facility failed to ensure the right to personal privacy during personal care for 4 of 5 residents (Resident #5, Resident #6, Resident #7, and Resident #8) reviewed for dignity. 1. The facility failed to ensure Resident #5 was provided with privacy when checking for incontinence. 2. The facility failed to ensure Resident #6 was provided with privacy during incontinent care. 3. The facility failed to ensure Resident #7 was provided with privacy when checking for incontinence. 4. The facility failed to ensure Resident #8 was provided with privacy during incontinent care. These failures could affect residents by contributing to poor self-esteem, and decreased self-worth and quality of life. Findings included: 1. Record review of Resident #5's Admission Record, dated 11/22/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Hypertension (high blood pressure), Type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), Morbid Obesity (disorder that involves having too much body fat) , Tracheostomy status (artificial opening in the windpipe to assist with breathing). Record review of Resident #5's Care Plan, last reviewed 9/23/24, revealed: I am incontinence [sic] of bowel and bladder .INCONTINENT CARE Q SHIFT AND PRN Record review of Resident #5's quarterly MDS assessment, dated 10/18/24, revealed the resident's cognitive skills for daily decision making were severely impaired. Further review of this document revealed Resident #5 was incontinent of bowel and bladder. Observation of while CNA A checked Resident #5 for incontinence, on 11/21/24 beginning at 8:45 am, revealed CNA A did not pull the privacy curtain or close the blinds when she checked Resident #5 for incontinence. Resident #5 did not respond to the investigator's questions. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675171	A. Building B. Wing	11/22/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #6's Admission Record, dated 11/22/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Dysphagia (difficulty swallowing), Type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), Tracheostomy status (artificial opening in the windpipe to assist with breathing), and Gastrostomy status (surgical opening into the stomach for the introduction of food). Record review of Resident #6's Care Plan, last reviewed 9/23/24, revealed: .I require bowel and bladder incontinence care . Record review of Resident #6's quarterly MDS assessment, dated 9/13/24, revealed the resident's BIMS score was 15, suggesting intact cognition. Further review of this document revealed Resident #6 was incontinent of bowel and bladder. Observation of incontinent care for Resident #6, on 11/22/24 beginning at 11:19 am, revealed CNA C did not pull the privacy curtain completely closed while he provided care for Resident #6. 3. Record review of Resident #7's Admission Record, dated 11/22/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Seizures (burst of uncontrolled electrical activity between brain cells causing temporary abnormalities in muscle tone or movements, behaviors, sensations or states of awareness), Hypertension (high blood pressure), Anoxic Brain Damage (caused by complete lack of oxygen to the brain), and Chronic Respiratory Failure with Hypoxia (lung damage preventing adequate oxygenation of the blood). Record review of Resident #7's Care Plan, last reviewed 9/23/24, revealed: .I require bowel and bladder incontinence care . Record review of Resident #7's comprehensive MDS assessment, dated 10/6/24, revealed the resident's cognitive skills for daily decision making were severely impaired. Further review of this document revealed Resident #7 was incontinent of bowel and had a catheter. Observation of while RN D checked Resident #7 for incontinence and interview, on 11/22/24 beginning at 11:44 am, revealed RN D left the door and blinds open and did not pull the privacy curtain completely closed when she checked Resident #7 for incontinence. RN D said when care was provided to residents the door and the blinds were supposed to be closed and the privacy curtain pulled all the way. RN D said this was important because the residents were vulnerable, and their privacy must be protected. RN D further stated if the resident's privacy was not protected, they may feel humiliated and unsafe. Resident #7 did not respond to the investigator's questions. 4. Record review of Resident #8's Admission Record, dated 11/22/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Hypertension (high blood pressure), Nontraumatic Intracerebral Hemorrhage (bleeding in the brain), and Chronic Respiratory Failure (lung damage preventing adequate oxygenation of the blood), Tracheostomy status (artificial opening in the windpipe to assist with breathing), and Gastrostomy status (surgical opening into the stomach for the introduction of food). Record review of Resident #8's Care Plan revealed it did not include incontinent care. (continued on next page)

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	11/22/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #8's comprehensive MDS assessment, dated 10/31/24, revealed the resident's cognitive skills for daily decision making were severely impaired. Further review of this document revealed Resident #8 was incontinent of bowel and had a catheter. Observation of incontinent care for Resident #8, on 11/22/24 beginning at 12:02 pm, revealed CNA E and CNA C did not pull the privacy curtain completely closed when Resident #8 was provided incontinent care. Resident #8 did not respond to the investigator's questions. During an interview on 11/22/24 at 2:11 pm, CNA E said when care was provided to residents the privacy curtain should be closed all the way because it was the residents' right to have privacy. CNA E further stated not providing the residents privacy could cause embarrassment and shame. During an interview on 11/22/24 at 2:23 pm, CNA C said the residents' privacy curtain should be pulled all the way when care was provided to residents. CNA C said this was important because it was the residents' right. CNA C further stated residents may feel uncomfortable when privacy was not provided. During an interview on 11/22/24 at 2:38 pm, CNA A said when care was provided to residents the privacy curtain should be pulled completely closed and the door and blinds should be closed. CNA A said this was important, so the resident felt protected. CNA A further stated if someone entered the resident's room, they were not able to see the resident receiving care. CNA A said when residents' privacy was not protected, they could feel embarrassed and ashamed. During an interview on 11/22/24 at 4:34 pm, the DON said she expected the staff to provide the residents with privacy when care was provided. The DON further stated the door, blinds and privacy curtains should be closed during resident care because the residents had a right to privacy. During an interview on 11/22/24 at 5:54 pm, the Administrator said she expected staff to close the door, blinds, and privacy curtains all the way when resident care was provided for dignity purposes. The Administrator further stated the residents could be affected emotionally if their privacy was not respected. Record review of the facility's policy titled Resident Rights, revised February 2021, revealed: .Employees shall treat all residents with kindness, respect, and dignity . 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to .privacy . Record review of the facility's policy titled Perineal care, revised February 2018, revealed: .Avoid unnecessary exposure of the resident's body . Record review of the facility's policy titled Dignity, revised February 2021, revealed: .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem . 1. Residents are treated with dignity and respect at all times . 11. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures .

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	11/22/2024

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 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** 39251 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 objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 8 residents (Resident #8) reviewed for care plans. The facility failed to develop a person-centered care plan with interventions that addressed Resident #8's following care areas: Cognitive Loss/Dementia, Visual Function, Communication, Urinary Incontinence and Indwelling catheter, Psychosocial Well-Being, Activities, Nutritional Status, Feeding Tube, Dehydration/Fluid Maintenance, Pressure Ulcer, Physical Restraints, and Functional Abilities related to self-care and mobility. This deficient practice could affect residents and place them at risk for not having their needs and preferences met. Findings included: Record review of Resident #8's Admission Record, dated 11/22/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Type 2 Diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), Hyperlipemia (high levels of fat in the blood), Dry Eye Syndrome, Hypertension (high blood pressure), Nontraumatic Intracerebral Hemorrhage (bleeding in the brain), and Acute/Chronic Respiratory Failure (lung damage preventing adequate oxygenation of the blood), GERD (digestive disease in which stomach acid or bile irritates the food pipe lining) , Constipation, Shortness of Breath, Altered Mental Status, Localized Edema (swelling), Tracheostomy status (artificial opening in the windpipe to assist with breathing), and Gastrostomy status (surgical opening into the stomach for the introduction of food). (continued on next page)

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	11/22/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #8's comprehensive MDS assessment, dated 10/31/24, revealed the resident's cognitive skills for daily decision making were severely impaired. Further review of the MDS revealed: Resident #8 was dependent (Helper does all of the effort and the resident none of the effort to complete the activity. Or, the activity requires the assistance of 2 or more helpers) for eating, oral/personal hygiene, toileting hygiene, shower/bathe self, dressing, putting on/taking off footwear, repositioning, and transfers; Resident #8 had an indwelling catheter and was always incontinent of bowel; active diagnoses included: Hypertension, GERD, Diabetes Mellitus, Hyperlipidemia, Cerebrovascular Accident, Transient Ischemic Attack, or Stroke. Additional active diagnoses included: Dry Eye Syndrome, Constipation, Shortness of Breath, Altered Mental Status, Localized Edema, and Tracheostomy Status; required a feeding tube; was at risk of developing pressure ulcers/injuries and required a pressure reducing device for chair and bed; received anticoagulant (medication that prevents blood clots from forming) and antiplatelet (medication that prevents blood clots from forming) medication; required oxygen therapy, suctioning, and tracheostomy care; ST to start 10/28/24, PT to start 10/25/24; resident used bed rail daily; and preferred to remain in the facility. The MDS assessment revealed related care area (CAA) triggers included Cognitive Loss/Dementia, Visual Function, Communication, Urinary Incontinence and Indwelling catheter, Psychosocial Well-Being, Activities, Nutritional Status, Feeding Tube, Dehydration/Fluid Maintenance, Pressure Ulcer, and Physical Restraints. Record review of Resident #8's Care Plan revealed one focus area: An actual fall on 11/1/24. Record review of Resident #8's Order Summary Report, dated 11/22/24, revealed orders for the following: . NPO diet . BOLSTERS/ SCOOP MATTRESS TO BED-MONITOR FOR PLACEMENT Q SHIFT every shift for FALL MANAGMENT, .MAY HAVE 1/4 SIDE RAILS UP AS NEEDED FOR ENABLER, MAY HAVE ALCOHOL AND DIET OF CHOICE DURING ACTIVITIES .TUBE FEEDING ORDERS: DIABETESOURCE AT 65ML/HR X22HR. FW AT 40ML/HR X22HR. MAY BE DOWN FOR ADLS every shift, VERIFY TUBE PLACEMENT BY AUSCULATATION [sic] OF AIR BOLUS AND ASPIRATION OF GASTRIC RESIDUAL AFTER TUBE PLACEMENT AND BEFORE ADMINISTRATION OF MEDICATIONS, FEEDING AND FLUSHES. every shift . During an interview on 11/22/24 at 3:53 pm, RN I said she completed Resident #8's MDS assessment but did not complete the care plan, adding she was responsible for completing Resident #8's care plan. RN I further stated the care plans were completed after the MDS assessment was competed. RN I said it was important for care plans to be complete so that everyone was aware of the plan of care and knows how to appropriately care for the residents. During an interview on 11/22/24 at 4:34 pm, the DON said comprehensive care plans should be completed within 2 weeks of the residents' admission, after the MDS assessment was completed. The DON further stated the MDS assessment, and the care plans should contain the same information. The DON said it was important for the care plans to be complete to accurately reflect how to care for the residents and meet their needs. (continued on next page)

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	11/22/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Care Plans, Comprehensive Person-Centered, revised December 2016, 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 . 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment . 8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Describe 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 . e. Include the resident's stated goals upon admission and desired outcomes; f. Include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire; g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems; i. Build on the resident's strengths; j. Reflect the resident's expressed wishes regarding care and treatment goals; k. Reflect treatment goals, timetables and objectives in measurable outcomes; l. Identify the professional services that are responsible for each element of care; m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; n. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and o. Reflect currently recognized standards of practice for problem areas and conditions . 12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS) .

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	11/22/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals, and preferences for 2 of 2 (Resident #8 and Resident #9) reviewed for respiratory care. 1. The facility failed to ensure the aerosol tubing for Resident #8 was replaced after it was found on the floor. 2. The facility failed to ensure the aerosol tubing for Resident #9 was replaced after it was found on the floor. This deficient practice could affect residents and place them at risk for respiratory infection and decline in health. Findings included: 1. Record review of Resident #8's Admission Record, dated 11/22/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Acute/Chronic Respiratory Failure (lung damage preventing adequate oxygenation of the blood), Shortness of Breath, and Tracheostomy status (artificial opening in the windpipe to assist with breathing). Record review of Resident #8's comprehensive MDS assessment, dated 10/31/24, revealed the resident's cognitive skills for daily decision making were severely impaired. Further review of the MDS revealed Resident #8 required oxygen and tracheostomy care. Record review of Resident #8's Care Plan revealed it did not include Tracheostomy Status. Observation of incontinent care for Resident #8 on 11/22/24 beginning at 12:02 pm, revealed the aerosol tubing for the tracheostomy fell on the floor. CNA C picked up the aerosol tubing and placed it on the side table. CNA E left the room to notify the nurse; LVN J entered Resident #8's room and reconnected the aerosol tubing that was found on the floor to Resident #8's trach. 2. Record review of Resident #9's Admission Record, dated 11/22/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: Dementia, Acute Respiratory Failure (lung damage preventing adequate oxygenation of the blood), and Tracheostomy status (artificial opening in the windpipe to assist with breathing). Record review of Resident #9's quarterly MDS assessment, dated 8/17/24, revealed the resident's BIMS score was 3, suggesting severely impaired cognition. Further review of the MDS revealed Resident #9 required oxygen and tracheostomy care. Record review of Resident #9's Care Plan, reviewed 9/23/24, revealed: Patient has tracheostomy. At risk for complications including .infection . (continued on next page)

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	11/22/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/22/24 at 12:00 pm, revealed CNA E found Resident #9's aerosol tubing for tracheostomy on the floor, picked it up and placed it on the side table. CNA E left the room to notify the nurse. LVN J entered Resident #9's room and reconnected the aerosol tubing that was found on the floor to Resident #9's trach. During an interview on 11/22/24 at 12:53 pm, LVN J said the CNA E did not tell her the aerosol tubing for Resident #8 and Resident #9 was on the floor, adding she saw the tubing on the tables, so she just reconnected them. LVN J said if she had known the tubing had been on the floor, she would have told the RT so that the tubing system could be replaced. During an interview on 11/22/24 at 2:11 pm, CNA E said she had not mentioned to LVN J the aerosol tubing for Resident #8 and Resident #9 were found on the floor. CNA E further stated it was important to mention to the nurse if the aerosol tubing had been on the floor so that it could be replaced with a clean one for sanitary reasons. CNA E said reconnecting tubing that had been on the floor could cause an infection. During an interview on 11/22/24 at 4:34 pm, the DON said she expected the staff to mention if an aerosol tubing had been on the floor due to the risk for infection. Record review of the facility's policy titled Tracheostomy Care, undated, revealed: . It is the policy of this facility to provide tracheostomy care in accordance with current standards of practice to ensure airway patency, maintain skin integrity and prevent infection .

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	11/22/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm 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. 39251 Based on observation, interview, and record review the facility failed to ensure, in accordance with state and federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 2 of 6 medication carts (Respiratory Treatment Cart #1 and Wound Treatment Cart #2) reviewed for medication storage. 1. The facility failed to ensure the respiratory treatment cart on the 300 hall was locked. 2. The facility failed to ensure the wound treatment cart was locked on (2) occasions. This failure could place residents at risk of medication misuse and drug diversion. Findings included: 1. Observation and interview on 11/21/24 at 10:54 am revealed Respiratory Treatment cart #1 on the 300 hall was observed to be unlocked and unattended by the state investigator and the DON. There were mobile residents moving throughout the facility. RT H said the treatment cart was not supposed to be left unlocked. The DON said there were no medications in the cart and it only had respiratory supplies, such as trachs. 2. Observation on 11/22/24 at 9:00 am revealed LVN B left the Wound Treatment Cart #2 unlocked on the 200 hall when she entered a resident's room for an assessment. Observation on 11/22/24 at 9:14 am revealed LVN B left the Wound Treatment Cart #2 unlocked on the 300 hall when she entered a resident's room for an assessment. Observation and interview on 11/22/24 at 9:23 am revealed Wound Treatment Cart #2 contained treatments, such as: Triad (cream that help maintain a moist healing environment), Ammonium Lactate (cream used to treat dry skin and minor kin irritation), Wound Cleanser and Barrier Ointment. LVN B said there were mobile residents in the facility and the cart should not be unlocked because someone can get into it. LVN B further stated someone could ingest a product that could cause an adverse reaction. During an interview on 11/22/24 at 4:34 pm, the DON said she expected medications and treatment carts to be locked by the staff responsible for it when unattended. The DON further stated this was important so that people did not have access to the medications inside the carts, including mouthwash and respiratory treatments. The DON said it was possible for a resident or visitor to obtain access to the contents of the cart, ingest something, and have an adverse reaction. (continued on next page)

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	11/22/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled, Storage of Medications revised August 2020, revealed: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others .

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	11/22/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on observations, interviews, 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 diseases and infections for 7 of 7 residents (Residents #1, Resident #2, Resident #4, Resident #5, and Resident #6, Resident #7, and Resident #8) reviewed for infection control. 1. The facility failed to use proper infection control practices during perineal care for Resident #1. 2. The facility failed to use proper infection control practices when checking Resident #2 for incontinence. 3. The facility failed to use proper infection control practices during incontinent care for Resident #4. 4. The facility failed to use proper infection control practices when checking Resident #5 for incontinence. 5. The facility failed to use proper infection control practices during perineal care for Resident #6. 6. The facility failed to use proper infection control practices when checking Resident #7 for incontinence. 7. The facility failed to use proper infection control practices during perineal care for Resident #8. These deficient practices could place residents at risk for infection and decline in health. Findings included: 1. Record review of Resident #1's Admission Record, dated 11/21/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: Type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy) , Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities) , Acute/Chronic Respiratory Failure (lung damage preventing adequate oxygenation of the blood), Morbid Obesity (disorder that involves having too much body fat), Myotonic Muscular Dystrophy (disorder that cause muscle weakness and wasting), Asthma (condition in which airways become inflamed, narrow, and produce extra mucus, making it difficult to breathe), Spina Bifida (a defect that occurs when the neural tube that develops into the spinal cord and brain does not close properly). (continued on next page)

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	11/22/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's comprehensive MDS assessment, dated 10/11/24, revealed the resident's BIMS score was 15, suggesting intact cognition. Further review of the MDS assessment revealed Resident #1 required substantial/maximal assistance with toileting hygiene and was frequently incontinent of bowel and bladder. Record review of Resident #1's Care Plan, reviewed 10/25/24, revealed: .I require assistance with my ADL's . I require bowel and bladder incontinence care . Observation of skin assessment and perineal care for Resident #1 on 11/22/24 beginning at 9:14 am, revealed CNA K removed Resident #1's wet brief, dropped a clean brief on the floor, and retrieved another clean brief without changing gloves or performing hand hygiene. Further observation revealed CNA K completed perineal care, picked up the brief off the floor and placed it in Resident #1's drawer and replaced the resident's table without changing gloves or performing hand hygiene. Further observation revealed CNA K and LVN B removed their gloves and LVN B washed her hands for 12 seconds. During an interview on 11/22/24 at 11:00 am, CNA K said she did not change her gloves after removing Resident #1's dirty brief and before placing the clean brief. CNA K further stated she was expected to change gloves before she touched anything clean, when going from clean to dirty, so that she did not transfer any germs or infections, such as, feces to the clean areas of the resident. CNA K said she should have disposed of the brief that fell on the floor, but instead placed it in the resident's dresser drawer. CNA K further stated it was important that she disposed of the brief that fell on the floor because it could have been contaminated, adding a lot of things could be on that floor. CNA K said she also contaminated the table because Resident #1 had personal belongings and food on the table and there was a possibility of cross contamination. CNA K said she was not thinking while she was providing care to Resident #1. 2. Record review of Resident #2's Admission Record, dated 11/22/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities), Quadriplegia (paralysis from the neck down, affecting all four limbs), and Anxiety (feeling of dread, fear, or uneasiness). Record review of Resident #2's comprehensive MDS assessment, dated 10/11/24, revealed the resident's BIMS score was 15, suggesting intact cognition. Further review of the MDS assessment revealed Resident #2 had a catheter and was frequently incontinent of bowel. Record review of Resident #2's Care Plan, reviewed 9/23/24, revealed: .I require assistance with my ADL's .I require bowel incontinence care . Observation of LVN B checking Resident #2 for incontinence, on 11/22/24 at 9:00 am, revealed LVN B washed her hands for 8 seconds after completing the assessment. 3. Record review of Resident #4's Admission Record, dated 11/21/24, revealed the resident was readmitted to the facility on [DATE] with diagnoses that included: Sepsis (life-threatening complication of an infection), Dementia (group of thinking and social symptoms that interferes with daily functioning), Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities) , Anxiety (feeling of dread, fear, or uneasiness), and Urinary Incontinence. (continued on next page)

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	11/22/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's comprehensive MDS assessment, dated 8/19/24, revealed the resident's BIMS score was 7, suggesting severely impaired cognition. Further review of the MDS assessment revealed Resident #4 had a catheter and was frequently incontinent of bowel. Record review of Resident #4's Care Plan, reviewed 9/23/24, revealed: .I am At risk for skin integrity loss R/T incontinence of bowel and bladder .Observe skin for breakdown each shift and report any red or open areas . Observation of incontinent care for Resident #4 on 11/22/24 at 5:25 pm, revealed CNA F wiped Resident #4's vaginal area and turned her onto her side. Further observation revealed CNA F changed gloves without performing hand hygiene and wiped Resident #4's anal area and buttocks. CNA F removed the dirty brief and chuck pad and placed a clean chuck pad and brief under Resident #4 without changing gloves or performing hand hygiene. Further observation revealed CNA F removed the gloves, touching the outside of the gloves with her bare hand, without performing hand hygiene and donned clean gloves. CNA F positioned Resident #4 onto her back, removed wipes from the package and wiped her vaginal area again using the same surface of the wipe repeatedly. CNA F changed gloves without performing hand hygiene. Resident #4 was turned to the opposite side and CNA G removed the soiled brief and chuck pad and placed the clean brief and chuck pad without changing gloves or performing hand hygiene. CNA F pushed remaining wipes into the package and washed her hands for 9 seconds. 4. Record review of Resident #5's Admission Record, dated 11/22/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Hypertension (high blood pressure), Type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), Morbid Obesity (disorder that involves having too much body fat) , Tracheostomy status (artificial opening in the windpipe to assist with breathing). Record review of Resident #5's Care Plan, last reviewed 9/23/24, revealed: I am incontinence [sic] of bowel and bladder .INCONTINENT CARE Q SHIFT AND PRN Record review of Resident #5's quarterly MDS assessment, dated 10/18/24, revealed the resident's cognitive skills for daily decision making were severely impaired. Further review of this document revealed Resident #5 was incontinent of bowel and bladder. Observation of skin assessment for Resident #5, on 11/22/24 beginning at 8:45 am, revealed CNA A donned PPE before entering Resident #5's room without performing hand hygiene. 5. Record review of Resident #6's Admission Record, dated 11/22/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Dysphagia (difficulty swallowing), Type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), Tracheostomy status (artificial opening in the windpipe to assist with breathing), and Gastrostomy status (surgical opening into the stomach for the introduction of food). Record review of Resident #6's Care Plan, last reviewed 9/23/24, revealed: .I require bowel and bladder incontinence care . Record review of Resident #6's quarterly MDS assessment, dated 9/13/24, revealed the resident's BIMS score was 15, suggesting intact cognition. Further review of this document revealed Resident #6 was incontinent of bowel and bladder. (continued on next page)

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	11/22/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of incontinent care for Resident #6, on 11/22/24 beginning at 11:19 am, revealed CNA C performed hand hygiene, donned PPE, and then donned an additional pair of gloves. Further observation revealed after CNA C wiped Resident #6's vaginal area, he removed the top pair of gloves, removed a new pair of gloves from the box and donned the gloves over the pair he was already wearing. CNA C turned Resident #6 onto her side, wiped her anal area, and disposed of the soiled brief. CNA C removed the top pair of gloves and wiped Resident #6's buttocks. Resident #6 positioned herself onto her back. CNA C removed his gloves, removed a clean pair of gloves from the box without performing hand hygiene, donned the clean gloves and completed the perineal care. 6. Record review of Resident #7's Admission Record, dated 11/22/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Seizures (burst of uncontrolled electrical activity between brain cells causing temporary abnormalities in muscle tone or movements, behaviors, sensations or states of awareness), Hypertension (high blood pressure), Anoxic Brain Damage (caused by complete lack of oxygen to the brain), and Chronic Respiratory Failure with Hypoxia (lung damage preventing adequate oxygenation of the blood). Record review of Resident #7's Care Plan, last reviewed 9/23/24, revealed: .I require bowel and bladder incontinence care . Record review of Resident #7's comprehensive MDS assessment, dated 10/6/24, revealed the resident's cognitive skills for daily decision making were severely impaired. Further review of this document revealed Resident #7 was incontinent of bowel and had a catheter. Observation of RN D checking Resident #7 for incontinence and interview, on 11/22/24 beginning at 11:44 am, revealed RN D did not perform hand hygiene prior to donning PPE. RN D said she was expected to perform hand hygiene before and after care was provided to residents to prevent the spread of infections, and to protect the client and herself from MRDOs. 7. Record review of Resident #8's Admission Record, dated 11/22/24, revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Hypertension (high blood pressure), Nontraumatic Intracerebral Hemorrhage (bleeding in the brain), and Chronic Respiratory Failure (lung damage preventing adequate oxygenation of the blood), Tracheostomy status (artificial opening in the windpipe to assist with breathing), and Gastrostomy status (surgical opening into the stomach for the introduction of food). Record review of Resident #8's Care Plan revealed it did not include incontinent care. Record review of Resident #8's comprehensive MDS assessment, dated 10/31/24, revealed the resident's cognitive skills for daily decision making were severely impaired. Further review of this document revealed Resident #8 was incontinent of bowel and had a catheter. Observation of incontinent care for Resident #8, on 11/22/24 beginning at 12:02 pm, revealed CNA C donned two pairs of gloves. Further observation revealed CNA E wiped Resident #8's genital and anal area, reached into the package of wipes and removed wipes without changing gloves or performing hand hygiene. CNA C removed Resident #8's soiled brief and placed a clean brief without changing gloves or performing hand hygiene. (continued on next page)

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	11/22/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/22/24 at 9:42 am, LVN B said she was expected to wash her hands and sing Happy Birthday twice or for 20 seconds. LVN B said that was she did, she sang Happy Birthday twice in her head and that it was 20 seconds. LVN B said it was Important to perform hand hygiene for the recommended amount of time to get all the microbes off the hands and prevent cross contamination of any pathogens. During an interview on 11/22/24 at 2:11 pm, CNA E said she was expected to change gloves as needed, if they were soiled. CNA E further stated she was not required to change gloves until they were visibly soiled with feces. CNA E said she did not take the gloves off until she disposed of everything and then she washed her hands. CNA E said she usually took out all the wipes needed but was nervous and did not do that today. CNA E further stated it was important not to reach into the package of wipes with dirty gloves to avoid cross contamination, adding her hands may not have been soiled but she touched the resident. CNA E said she should have changed gloves when going form dirty to clean. During an interview on 11/22/24 at 2:23 pm, CNA C said he did not know if double gloving was acceptable or not. CNA C further stated he had not been told not to wear more than one pair of gloves at a time. CNA C said he felt more protected with more than one pair of gloves on because sometimes the gloves tore. CNA C further stated he assumed when he removed the top pair of gloves, the second pair were clean so it was ok. CNA C said he was expected to perform hand hygiene before and after entering a resident's room and if your hands became soiled and when going from a dirty area to a clean area. During an interview on 11/22/24 at 2:38 pm, CNA A said she was expected to wash her hands before putting on PPE and after taking it off. CNA A further stated it was important to perform hand hygiene after touching a dirty surface for infection control. During an interview on 11/22/24 at 3:07 pm, CNA F said she was expected to sanitize her hands when changing gloves. CNA F further stated this was important to prevent bacteria from cross contamination. CNA F said the bacteria could cause the resident to develop a yeast infection from cross contamination. CNA F said she was expected to change gloves when going from a clean area to a dirty one, such as after removing a dirty brief and before putting on a clean one. CNA F said she was expected to wash her hands while she sang Happy Birthday twice, about 20 seconds. CNA F further stated it was important to perform hand hygiene for the recommended amount of time to ensure that her hands were clean because there's no telling what's under your fingernails and this could cause cross contamination. CNA F said it was important not to reach into the package of wipes without performing hand hygiene because it would get contaminated. (continued on next page)

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	11/22/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/22/24 at 4:34 pm, the DON said she was responsible for ensuring staff followed infection control policies. The DON further stated she expected staff to follow the hand hygiene policy and wash their hands for the adequate amount of time, 20 seconds, sanitize between glove changes, and wash their hands when they were visibly soiled. The DON said she did not know what the hand hygiene policy said. The DON further stated it was important for the staff to perform hand hygiene for the recommended amount of time to avoid the spread of infections. The DON said she expected staff to change gloves between clean and dirty areas, for example: after removing a dressing, after removing the brief and before cleaning the resident, and before putting on the clean brief. The DON said this was important to prevent infection. The DON said double gloving was not acceptable, because you can get stuff in between them and cannot perform hand hygiene of you don't take them both off. The DON further stated staff should not reach into the package with dirty gloves, for infection control purposes, adding the staff contaminated the package when this was done putting the residents at risk for infection. The DON said if a brief fell on the floor, she did not expect the staff to place the brief into the resident's dresser drawer due to infection control. During an interview on 11/22/24 at 5:54 pm, the Administrator said she expected staff to follow the policies, procedures related to infection control, hand hygiene, and standard precautions. The Administrator further stated the interdisciplinary team was responsible for ensuring staff followed infection control policies and procedures. The Administrator said it was important for staff to follow infection control policies and procedures to reduce exposure to infections and further stated infection control rates can be negatively affected. Record review of the facility's procedure titled, Perineal Care, revised February 2018, revealed: .Steps in the Procedure . 2. Wash and dry your hands thoroughly . Record review of the facility's guideline titled, Infection Control Guidelines for All Nursing Procedures, revised August 2012, revealed: .General Guidelines . 3. Employees must wash their hands for ten (10) to fifteen (15) seconds using antimicrobial or non antimicrobial soap and water under the following conditions: a. Before and after direct contact with residents . d. After removing gloves; e. After handling items potentially contaminated with blood, body fluids, or secretions . 4. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: a. Before and after direct contact with residents . f. Before moving from a contaminated body site to a clean body site during resident care; g. After contact with a resident's intact skin . i. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; and j. After removing gloves. Record review of the webpage https://www.cdc.gov/niosh/healthcare/hcp/pandemic/conserving-disposable-gloves.html, dated October 22, 2024, revealed: . the CDC does not routinely recommend double gloving as a part of Standard or Transmission based precautions . Record review of PDF at https://stacks.cdc.gov > cdc > cdc_153879_DS1, Topic 8: Ppe part 2 - gloves, undated, revealed: .Do not wear two pairs of gloves at once, which can .Spread germs when removing and replacing the top layer .Wearing two pairs of gloves at once is not recommended for routine care and can be an infection control risk . Record review of the webpage https://www.cdc.gov/clean-hands/about/index.html, dated February 16, 2024, revealed: .How it works .3. Scrub your hands for at least 20 seconds .