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	02/11/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46447 Based on observations, interviews, and record reviews, the facility failed to ensure that residents were free of significant medication errors for 1 (Resident #1) of 3 residents reviewed for pharmacy services. The facility failed to ensure Resident #1 was free of significant medication errors when Resident #1 was administered another resident's medications, atorvastatin (medication to treat high cholesterol), labetalol (medication to treat high blood pressure), and hydralazine (medication to lower blood pressure) by LPN A on 11/09/2024. This failure could place residents at risk of adverse reaction related to taking medications not ordered by the physician. Findings included: Record review of Resident #1's Admission Record, dated 02/06/2025, reflected Resident #1 was a [AGE] year-old female. She was initially admitted on [DATE] and readmitted on [DATE]. She was noted to have diagnoses including anoxic brain damage (a condition in which the brain loses oxygen supply which could cause serious, permanent brain damage), chronic respiratory failure with hypoxia (a condition in which the lungs cannot adequately oxygenate the blood leading to low oxygen levels), and other secondary hypertension (elevated blood pressure). Record review of Resident #1's Quarterly MDS, signed as completed on 01/16/2025, reflected Resident #1 was not assessed for her mental status due to her having been rarely/never understood. She was documented as having hypertension. She was documented as not receiving scheduled or PRN (as needed) pain medications in the last 5 days reviewed for the assessment. She was documented as having received nutrition through a feeding tube and received oxygen therapy with tracheostomy (surgical procedure in the front of the neck to allow air to fill the lungs) care. Her medication was documented to include anticoagulant (medication to treat and prevent blood clots), antiplatelet (medication to prevent blood clots), and anticonvulsant (medication to help prevent or treat seizures) medications. Record review of Resident #1's Care Plan, dated as last review completed 01/24/2025, reflected Resident #1 was taking medication for the treatment of seizures and nursing staff were required to assess resident for any change in condition and report any abnormal findings to the MD and family. Record review of Resident #1's Progress Notes reflected: (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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NAME OF PROVIDER OR SUPPLIER Meridian Care		STREET ADDRESS, CITY, STATE, ZIP CODE 7181 Crestway Dr San Antonio, TX 78239	

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An Activities Note by the DON, effective date 11/09/2024 at 10:55 p.m. and noted to be LATE ENTRY, Nurse [LPN A] reports that she mistakenly administered incorrect medications to resident via peg tube [a type of feeding tube] at 2002 [08:02 p.m.] during HS med pass [medication administration at bedtime]. Resident was administered atorvastatin, labetalol, [sic] hydralazine. Nurse reports that she realized [sic] mistake less than halfway through medication pass and stopped immediately. Resident did receive correct scheduled medications as well. [MD D] was notified, and residents [sic] were reported and stable. Resident will continue on vital sign monitoring x72 hours. Resident's [family member] spoke with both DON, nurse [LPN A] 2-10 [02:00 p.m. to 10:00 p.m.] shift and [LPN B] 10-6 [10:00 p.m. to 06:00 a.m.] shift after incident. [Family member] reports that [second family member] was notified by her as she also has access to video monitoring system that they reviewed. - A Nursing Note by LPN A, effective date 11/10/2024 at 06:57 a.m., Resident assessed in am. Alert and awake. No s/s of pain or discomfort. Vital signs were noted and within normal range. - A Nursing Note by LPN B, effective date 11/10/2024 at 07:20 a.m., Alert and responsive head to toe assessment completed this morning pt [patient] is stable no signs of distress noted .patient was stable throughout the night. Will continue to monitor. Vital signs were noted and within normal range. - A Nursing Note by LPN A, effective date 11/10/2024 at 07:30 a.m., No s/s of pain or discomfort. Spoke to [family member]. Vital signs were noted and within normal range. - A Nursing Note by LPN A, effective date 11/10/2024 at 11:30 a.m., No s/s of pain or discomfort noted. Vital signs were noted and within normal range. - A Nursing Note by LPN B, effective date 11/10/2024 at 12:00 p.m., Patient continue on observation for medication, pt is stable .will continue to monitor. Vital signs were noted and within normal range. - A Nursing Note by LPN A, effective date 11/10/2024 at 01:08 p.m., No s/s of pain or discomfort noted. Vital signs were noted and within normal range. - A Nursing Note by LPN A, effective date 11/10/2024 at 02:30 p.m., No s/s of distress noted. Vital signs were noted and within normal range. - A Nursing Note by RN E, effective date 11/10/2024 at 10:00 p.m., Assessed resident due to medication error on 11/9/24 at approximately 6:45pm. [Resident #1] has No [sic] known allergies to medications. Medical history of seizures, HTN [hypertension], respiratory failure and anoxic brain injury. Upon entering room, resident resting with eyes closed. Opens eyes to sound of my voice. No distress noted. Remains stable at this time. Lung sounds are clear .Nurse reports resident Tolerating [sic] feeding well, with minimal residual and active bowel sounds. No adverse reaction noted at this time. MD and RP aware. Nurse will continue to monitor VS closely. Vital signs were noted and within normal range. - A Nursing Note by the DON, effective date 11/12/2024 at 09:29 a.m. and noted to be LATE ENTRY, Resident assessed .RT [respiratory therapist's name] in room with resident. Nurse [nurse's name] to administer medication. No s.s [sic] of distress noted. Vital signs were noted and within normal range. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility document labeled Medication Error, numbered 1554, and dated 11/09/2024 at 08:00 p.m. reflected a copy of the wording documented in the Activities Note by the DON on 11/09/2025 at 10:55 p. m. under incident description. Immediate action taken included Immediately assessed resident and found stable and reported to MD. Request to continue to monitor vs [vital signs] monitoring hourly. In contact with family member spoke to [named family member and relation]. Resident #1 noted to not be sent to the hospital. No injuries observed was noted for at the time of the incident. The family member was noted to be notified on 11/09/2024 at 10:50 p.m. and the physician on 11/09/2024 at 11:00 p.m. Record review of facility document labeled Nursing Assessment Form #17 with Resident #1's name, dated 11/09/2024 at 08:15 to 11/12/2024 at 10:00 p.m. to 6:00 a.m. shift, reflected a completed 72-hour monitoring assessment of Resident #1, which included: vital signs, pupil size and reaction, extremities, Glascow coma scale, seizure, headache, and vomiting. Vital signs and other monitoring scales were noted as completed and within normal range. Record review of facility Concern/Grievance Report, dated 11/09/2024 and initiated by Resident #1 family member, reflected under comments that the medication error was reported to family and the physician was notified, vital signs were being monitored, the nurse was counseled, her skills were validated, the policy and procedures were reviewed by the nurse, the resident was assessed, and the medications were reviewed by the physician. A copy of the facility policy, Adverse Consequences and Medication Errors, dated revised April 2014, was included with the grievance report, and had a hand-written statement I [LPN A] have reviewed medication error policy., with her signature on the bottom of the first page. Record review of facility document Competency Assessment Administering Medications through an Enteral Tube, dated 11/16/2024 and for employee LPN A, reflected LPN A demonstrated competencies for all competencies listed. RN E signed as observer/trainer with date completed on 11/17/2024. During an interview on 02/11/2025 at 03:50 p.m., the DON stated following the medication error, the nurse, LPN A was re-trained, and her skills check off was done. Attempted interview on 02/11/2025 at 04:22 p.m. with LPN A. Voice message left for requested return call. During an interview on 02/11/2025 at 05:18 p.m., MD D stated he was notified by the nurse (LPN A) about the medication error. He stated that since it was blood pressure medications, staff were told to monitor Resident #1 very closely, but nothing developed. MD D stated there were no adverse effects from the medication error. During an interview on 02/11/2025 at 05:52 p.m., the DON stated that she was notified of the medication error the evening of the incident through text by the Resident #1's family member, LPN A, and RN E. She stated that she expected staff to follow the facility policy for medication administration, providing medications to the right patient, the right medication, the right time, etc. The DON stated that she believed LPN A called the physician immediately since the nurses already had Resident #1's vitals by the time she had called them. The DON stated Resident #1's vitals were fine and there weren't any concerns for medication interactions. The DON stated that the doctor did not want to send Resident #1 out, only for staff to monitor the vital signs. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy Administering Medications, date revised December 2012, reflected: 5. The individual administering medications must verify the resident's identity before giving the resident his/her medications. Methods of identifying the resident include: a. Checking photograph attached to medical record; and b. if necessary, verifying resident identification with other facility personnel. 6. The individual administering the medication must check 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. Record review of facility policy Adverse Consequences and Medication Errors, date revised April 2014, reflected under the policy statement, Adverse consequences shall be reported to the Attending Physician and Pharmacist, and to federal agencies as appropriate. The policy defined an adverse consequence as an unpleasant symptom or event that is due to or associated with a medication, such as an impairment or decline in an individual's mental or physical condition or functional or psychosocial status. An adverse consequence may include: a. Adverse drug/medication reaction; b. Side effect; c. Medication-medication interaction; or d. Medication-food interaction. The policy defined a medication error as the preparation or administration of drugs or biological which is not in accordance with physicians' orders, manufacturers specifications, or accepted professional standards and principles of professional(s) providing services. An example of medication errors included an Unauthorized drug- a drug is administered without a physician's order.