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	03/28/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observation, interviews, and record reviews the facility failed to ensure residents had the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal for 1 of 5 residents (Resident #4) reviewed for grievances. The facility failed to fully investigate and follow up with Resident #4's and Resident #4's family member about a grievance report on 1/12/25 of being sprayed with an unknown substance by an unknown staff member. This failure could place residents at risk for not having their grievances resolved. The findings included: Record review of Resident #4's admission record dated 3/28/25, revealed a [AGE] year-old female resident was admitted on [DATE] and readmitted on [DATE] with diagnosis that included chronic respiratory failure with hypoxia (your lungs have a hard time loading your blood with oxygen or removing carbon dioxide with low levels of oxygen in your body tissues), morbid obesity due to excess calories, myotonic muscular dystrophy (Myotonic muscular dystrophy is a genetic condition characterized by progressive muscle weakness and wasting), other asthma (your airways narrow and swell and may produce extra mucus. This can make breathing difficult and trigger coughing, a whistling sound (wheezing) when you breathe out and shortness of breath.), acute and chronic respiratory failure with hypercapnia (high carbon dioxide), and spina bifida (a birth disorder in which the spine doesn't fully develop). Record review of Resident #4's quarterly MDS assessment, dated 12/30/24, revealed her cognition was intact for daily decision making. Under section GG the MDS showed the resident was dependent on a helper to do all the effort with rolling from left to right in bed, sitting to lying, or chair/bed to chair transfer. A record review of Resident #4's care plan conference dated 1/24/25 revealed, Resident #4 had episodes of agitation and frustration when requests were not made immediately and often refused care. Interventions included reapproach when calmer. Another care area showed Resident #4 had ineffective/spontaneous ventilation inability to sustained/required the use of a ventilator for breathing pattern with interventions to assess vent settings every shift and readjust as needed. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a grievance report, dated 1/12/25, revealed the weekend supervisor RN F filled out the form on behalf of Resident #4 and Resident #4's family member. The form stated Subject: (include specific details, dates, time, name of witness, ect (sic)): Resident reports she suspected her aide sprayed something in my room report this happened yesterday and request to know names of aides caring for her. Resident called 911 and was assessed by officers. Comments: (INCLUDE IMMEDIATE CORRECTIVE ACTION TAKEN ECT): Reassured Resident her request for specific aide not to care for her will be honored. Ensure resident not concerned about aerosol and her breathing. Obtained statement from aide of incident. Provided personal number to family member for follow up. Facilitated deep cleaning of room by [family memeber]. Report Received by [RN F's signature] date: 1/12/2025. Response by assigned department: (include action taken, investigation, plan to correct): Please have social worker follow up about calling emergency personnel. Department head signature: [was blank]. Administrator's signature [signed by the ADMIN] date: 1/13/25. Director of Nurse's signature: [signed by the DON] date: 1/13/25. Concerned Partys Response: [was blank]. Signature of DEPT Head Providing Response: [was blank]. Follow up Required? [was blank]. The form had a handwritten statement on the back [CNA G] statement- 1/12/15. [Resident #4] light was on. I entered to taker her off bed pan and put a grease on. I went down to pick up her charger from the floor and that's when a Mexican looking ladies came in and then walked out. I did not see her spray anything but [Resident #4] said who sprayed me? She was so angry she called 911 . Record review of the staff roster, dated 3/26/25, revealed CNA H was not found as a current employee. Record review of nursing department daily schedule/assignment sheet, dated 1/12/25, revealed CNA H and CNA I were assigned to Resident #4 hallway. CNA G was assigned to a different hallway. During an observation on 3/25/25 at 12:15 p.m. Resident #4 was in a private room. The light was off and there was a strong odor of urine. Resident #4 was awake lying in bed and had a ventilator. The Resident was laying on her side in bed facing the wall away from the door. During on observation on 3/28/25 at 12:03 p.m. an unknown staff was observed spraying a name brand name can of aerosol disinfectant spray down the 100 hallway. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/25/25 at 12:15 p.m. Resident #4 stated one night someone sprayed something on her. She stated she felt the mist of it hit her arm. She stated she was unable to turn herself and could not see who had entered her room and sprayed something. Resident #4 stated there was an aide already in her room picking up a charger off the floor. Resident #4 stated she requested to know who came in the room and CNA G told her no one else was in the room and laughed. The Resident stated she became very upset when no one would provide the name of the other staff who entered her room, and she called the police. The Resident stated no one from the facility ever followed up with her to find out who may have been in her room and wether they sprayed anything or not. The Resident stated she had not smelled anything, but she felt the mist and wetness after on her exposed arm and it upset her. During an interview on 3/27/25 at 2:44 p.m. the SW stated Resident #4 shuts her down and will not even let her in her room during meetings for her care. The SW stated she was unaware of the incident on 1/12/25 and had not spoken to or attempted to speak with Resident #4 about the incident. The SW stated the Administrator was responsible for reviewing all grievances. During an interview on 3/27/25 at 3:50 CNA G stated she saw a Hispanic CNA who she thought was an agency aide on 1/12/25 in the hallway. CNA G stated she did not see anyone else in the room or anyone who sprayed anything. CNA G stated staff is not allowed to have any sprays in resident rooms. During an interview on 3/27/25 at 4:18 p.m. the DON stated she was aware of the incident that occurred on 1/12/25 with Resident #4. The DON stated she thought it was a night shift CNA who was the Mexican lady in the statement, but she would need to ask RN F. The DON stated she recalled asking the resident if anything happened over the weekend of 1/12/25 and the residents told her no. The DON stated the resident would often refuses showers because she was particular on who she wanted to be showered by. The DON stated it was hard to be in Resident #4's room because of the strong odors. The DON stated aerosols were not allowed. The DON stated they did have cameras on the hallway but they could not see that far down the hallway to tell if someone had gone in her room and sprayed something. During an interview on 3/28/25 at 4:12 p.m. Resident #4's family member stated he came to visit the resident for her birthday after the incident. The family member stated they both filed a grievance with RN F about the incident and RN F provided her number to follow up about the incident. The family member stated on 1/19/25 they sent a text to inquire the status of the investigation and RN F never provided a response about the incident. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/25 at 5:09 p.m. RN F stated she was the weekend supervisor when Resident #4 reached out to her because she thought someone sprayed her with something in her room and had not seen who it was. RN F stated she asked the resident if she could smell anything and she stated no. RN F stated she thought the resident was worried about another aide, CNA H, who was already not allowed in her room, and the resident thought CNA H may have been the one in her room. RN F stated she asked Resident #4 if she was breathing ok and the resident just replied with expletives. RN F stated the resident could not tell her how the spray was affecting her. RN F stated she made sure there were no aerosols on the room or hallway. RN F stated the next day she interviewed CNA G and documented her statement. RN F stated CNA G told her she did not see anyone spray anything but there was another agency aide working with her. RN F stated she did not recall who the agency staff was, and the staff did not return to the facility or return her call for an interview. RN F stated she did not document who the 2nd unknown staff was or her attempts to interview the unknown staff. RN F stated she spoke with Resident #4 and the family member the next day, filled out the grievance, told them it was CNA G inside the room and an unknown agency staff standing outside the room, and provided her personal contact information. RN F stated the family member only reached out to her again to provide another point of contact. RN F stated she did not recall who the agency staff person was, but she knew the person was not on the schedule to return where it would have caused a threat to the resident. RN F stated she did not feel like this was an allegation of abuse, but the resident was just upset and needed some reassurance that CNA H was not in her room. During an interview on 3/27/25 at 5:45 p.m. the Administrator stated after the incident on 1/12/25 they did a sweep of all rooms and did locate 1 aerosol in a resident's room. The Administrator stated they had an issue with odor control in Resident #4's room. The Administrator stated they spoke with staff at the morning meeting not to use aerosols. The Administrator stated she did not know who the 2nd unknown person was she would have to review the schedule. The Administrator stated Resident #4 had her personal number to reach out to her if she had any concerns but had not said anything to her about the incident on 1/12/25. Record review of the facility's policy titled Grievances/Complaints, Filing, dated 2001 revised April 2007, stated Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances (e.g. the State Ombudsman). The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative. Policy Interpretation and Implementation .3. All grievances, complaints or recommendations stemming from a resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response .10. The grievance officer, the administrator and staff will take immediate action to prevent further potential violations of resident rights while the alleged violation is being investigated. 11. The administrator will review the findings grievance officer to determine what corrective actions, if any, need to be taken. 12. The resident, or person filing the grievance and/ or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems. a. The administrator, or his or her designee, will make such reports orally within __ working days of the filing of the grievance or complaint with the facility. b. A written summary of the investigation will also be provided to the resident, and a copy will be filed with the business office .

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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** 48366 Based on interview and record review the facility failed to ensure resident's care plans were revised by the interdisciplinary team after each assessment for 1 of 5 Residents (Resident #1) whose records were reviewed for care plan timing and revision, in that:. Resident #1's Care Plan did not reflect she required a mechanical lift for transfers. These deficient practices could affect any resident and could result in the inaccuracy of assessments and contribute to residents not receiving care for identified care needs. The findings were: Record review of Resident #1's admission record, dated 03/26/25, reflected a [AGE] year-old female initially admitted [DATE] and readmitted [DATE] with diagnoses to include hemiplegia and hemiparesis (paralysis and partial weakness of one side), age-related physical debility, lack of coordination, and acquired absence of left leg below knee. Record review of Resident #1's MDS assessment, dated 10/16/24, reflected Resident #1 was dependent (helper does ALL of the effort) for chair/bed-to-chair transfers and had a BIMS of 15 (indicating she was cognitively intact). Record review of Resident #1's care plan, last reviewed 02/19/25, revealed that mechanical lift transfer was not listed. Resident #1's care plan reflected Transfer: I require supervision, limited to extensive assistance in self-performance with 1-person physical assistance for all transfers. I may require more help on days I feel weak. Record review of 3613 for an intake reflected, [Resident #1] assist x2 with transfers. [Mechanical lift] may be used prn after HD treatments when resident is weaker. Record review of the facility's CNA Roster, dated 03/28/25, reflected Resident #1 was a transfer via mechanical lift. Record review of the facility's incident and accident report since 10/25/24 reflect no fall incidents for Resident #1. Interview on 03/28/25 at 10:50AM, CNA A revealed Resident #1 was transferred on 10/25/24 via mechanical lift, but LVN B decided to transfer resident with 2 people and no mechanical lift. Interview on 03/28/25 at 11:00AM. LVN B revealed Resident #1 was transferred on 10/25/24 via mechanical lift, however on this day they did not use the mechanical lift because all of them were taken. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/28/25 at 11:10 AM, Resident #1 revealed she had been transferred via mechanical lift for 3 years and she had told CNA A and LVN B to transfer her via mechanical lift during the incident on 10/25/24. Resident #1 revealed she felt weak during this transfer because she had been to dialysis earlier in the day. She revealed she felt scared and upset when the staff did not transfer her via mechanical lift. Interview on 03/28/25 at 11:15AM, the DOR revealed Resident #1 was not seen by physical therapy until after her fall in October due to insurance coverage. Interview on 03/28/25 at 11:15AM, MDS nurse revealed she had been working since Monday and could not provide any information about Resident #1. Interview on 03/28/25 at 12:45PM, MDS regional nurse consultant revealed care plans should be updated daily by looking at 24-hour report and incident/accident report. He revealed transfers for Resident #1 after the 10/25/24 incident may have been updated by the DON or other nurses if there was not an MDS nurse available during this time. He revealed the facility updated CNA assignment sheets to reflect how to transfer residents. Interview on 03/28/25 at 08:20PM, the DON revealed residents may not have mechanical lifts in their care plans, but that is why the facility used CNA tracking lists, because they had been looking for an MDS nurse to fulfill the MDS nurse duties. Record Review of the facility policy, revised March 2022, Care Plans, Comprehensive Person-Centered, reflected, 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 2 of 4 residents (Resident #1 and #2) reviewed for accidents and supervision. 1. Resident #1 was transferred without a mechanical lift on 10/25/24 and experienced pain to her right leg/sustained a distal fracture 2. Resident #2 was transferred by a single staff member instead of the required two during a mechanical lift on 09/25/2024 and the mechanical lift tipped over, dropping the resident, and resulting in a bump and laceration to her nose. The noncompliance was identified as PNC. The IJ began on 9/24/2024 and ended on 11/27/2024. The facility had corrected the noncompliance before the investigation began. This deficient practice could place residents at-risk of harm, serious injury, or death. The findings included: 1. Record review of Resident #1's admission record, dated 03/26/25, reflected a [AGE] year-old female initially admitted [DATE] and readmitted [DATE] with diagnoses to include hemiplegia and hemiparesis (paralysis and partial weakness of one side), age-related physical debility, lack of coordination, and acquired absence of left leg below knee. Record review of Resident #1's MDS assessment, dated 10/16/24, reflected Resident #1 was dependent (helper does ALL of the effort) for chair/bed-to-chair transfers and had a BIMS of 15 (indicating she was cognitively intact). Record review of Resident #1's care plan, last reviewed 02/19/25, revealed that mechanical lift transfer was not listed. Resident #1's care plan reflected Transfer: I require supervision, limited to extensive assistance in self-performance with 1-person physical assistance for all transfers. I may require more help on days I feel weak. Record review of Facility Provider Investigation Report, dated 11/12/24, reflected . On 10/25/24 at approx. [8:48 PM] Resident was lowered to ground during transfer from chair to bed by [LVN B] and [CNA A]. [LVN B] reported to DON that during transfer x2 resident became unable to bear weight and was lowered to ground by her and [CNA A]. Resident did not hit head during incident . [Resident #1] not on therapy PT/OT services due to pending insurance claim. [Resident #1] assist x2 with transfers. [Mechanical lift] may be used prn after HD treatments when resident is weaker. Resident stated she did not think she needed [mechanical lift] at this time due to feeling ok after HD and M-F regular staff being present. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's nurse's progress note, dated 10/25/24 at 08:48 PM, reflected staff was attempting to assist resident out of bed when due to residents non weight bearing status, more staff was needed to assist resident. Resident was then placed in a sitting position and when more staff arrived she was transferred to a geri chair using the [mechanical lift]. Patient did complain of pain to her right knee due to sitting up with her legs out in front of her. Head to toe assessment performed and resident is injury free and has been medicated with prn norco, md and don notified Record review of Resident #1's October 2024 MAR, accessed on 03/28/25, reflected Resident #1 received HYDROcodone-Acetaminophen Oral Tablet 5-325 MG . for moderate to severe pain from 10/26/24 through 10/29/24. Record review of Resident #1's Tibia/Fibula (two long bones located in lower leg) X-ray, dated 10/26/24, reflected no fracture or dislocation. Record review of Resident #1's November 2024 MAR, accessed on 03/28/25, reflected Resident #1 received HYDROcodone-Acetaminophen Oral Tablet 5-325 MG . for moderate to severe pain 11/04/24-11/07/24, 11/09/24, and 11/11/24. Record review of Resident #1's radiology results report for a knee X-ray, dated 11/11/24, reflected an acute distal femoral diametaphyseal fracture. Record review of Resident #1's hospital documents, dated 11/12/24, reflected orthopedic surgery spoke with patient and recommended no surgical intervention as patient is nonambulatory and has advance osteoporosis has no foot function and recommended nonoperative treatment with immobilizer on the right knee for 4 to 6 weeks with follow-up with orthopedic surgery as an outpatient in 3 weeks for repeat imaging . Interview on 03/28/25 at 10:50AM, CNA A revealed Resident #1 was supposed to be transferred via mechanical lift on 10/25/24, but LVN B decided to transfer resident with 2 people and no mechanical lift. Interview on 03/28/25 at 11:00AM, LVN B revealed Resident #1 was transferred via mechanical lift, however on this day (10/25/24) they did not use the mechanical lift because all of the mechanical lifts were taken. Interview on 03/28/25 at 11:10 AM, Resident #1 revealed she had been transferred via mechanical lift for 3 years and she had told CNA A and LVN B to transfer her via mechanical lift during the incident on 10/25/24. Resident #1 revealed she felt weak during this transfer because she had been to dialysis earlier that day. She revealed she felt scared and upset when the staff did not transfer her via mechanical lift. Interview on 03/28/25 at 11:15AM, the DOR revealed Resident #1 was not seen by physical therapy until after her fall in October (10/25/24) due to insurance coverage so they did not assess how Resident #1 should be transferred. Interview on 03/28/25 at 11:25AM, LVN C and CNA D revealed Resident #1 had been a mechanical transfer since she had been at this facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Record review of Resident #2's Face Sheet, dated 03/28/2025, reflected a [AGE] year-old female resident initially admitted to the facility on [DATE] with diagnoses of diabetes mellitus (a group of diseases that result in too much sugar in the blood), dementia (a group of thinking and social symptoms that interferes with daily functioning), and quadriplegia (paralysis of all 4 limbs). Record review of Resident #2's Comprehensive Person-Centered Care Plan, undated, reflected I require assistance with my ADL's because I [sic] Diagnosis of: Quadriplegia with interventions to include, Transfer: I require total assistance in self performance with 2 person physical assistance staff support using a mechanical Hoyer lift. Record review of Resident #2's Quarterly MDS Assessment, dated 12/23/2024, reflected that Resident #2 required assistance with chair/bed-to-chair transfer and was Dependent on staff, meaning Helper does ALL the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Record review of the Facility Provider Investigation Report, dated 10/01/2024, reflected, On 9/25/24 at approx. 930 am: Resident was transferred to gerichair from bed via hoyer by [CNA E] for breakfast. [CNA E] states that she transferred the resident to gerichair and as resident was lowered into gerichair hoyer lift tipped over. [CNA E] states she was able to catch resident to assist to floor. [LVN K went] in room and assessed resident. MD notified. Resident noted with abrasion to bridge of nose and head. [RT L and RT M] in room and evaluated, suctioned resident. [LVN K] called EMS to transport resident to ER for further eval. Resident positioned safely on floor until EMS arrived. [LVN K] informed family of incident and transfer for ER. [CNA E] suspended pending investigation. Record review of Resident #2's progress note, dated 09/25/2024 at 2:02 pm, reflected Resident returned from hospital. Abrasion to nose. CT and scans at hospital were negative. Continue neuros. MD notified. No new orders. Record review of Resident #2's Skin Assessment, dated 09/25/2024, reflected that Resident #2 had 1cm x 0. 1cm x MD well approximated laceration to bridge of nose. No discernable drainage. No odor. Interview on 03/26/2025 at 11:56 AM, the DON stated that CNA E performed an unauthorized 1-person mechanical lift on Resident #2. The DON stated it is explicitly against policy to perform a 1-person transfer with a mechanical lift, and that any employees who are observed performing a 1-person mechanical lift are terminated. The DON stated that the only injury to Resident #2 was a bump and laceration on her nose, and that tests at the hospital did not reveal further injury. Interview on 03/27/2025 at 3:30 PM, LVN K stated she remembered the incident and was there after the resident had fallen. LVN K stated the only injury observed was the laceration on the residents nose. LVN K stated that after the incident occurred, the Director of Rehabilitation at the facility assisted in ensuring all staff had mechanical lift-trainings and that all staff were observed to ensure they passed competency tests on the use of a mechanical lift. Record review of staff competencies reflected that all nursing staff (CNA's, LVN's, and Respiratory Therapists) had a competency test on mechanical lifts between 09/25/2024 and 10/28/2024. Interview on 03/28/25 at 02:00PM, Maintenance worker J revealed the facility checked mechanical lifts quarterly and they all currently work. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility implemented the following interventions: Interview with DON on 03/26/2024 at 11;56 AM revealed CNA E was not allowed to return to the facility due to not following facility policy regarding mechanical lifts. The DON further revealed that the mechanical lift had been replaced as a whole to prevent further injuries to residents. Observation on 03/28/25 at 01:45PM revealed there were 5 mechanical lifts in the building in working condition. Record review of Maintenance log 2024 reflected one mechanical lift was broken but fixed on 02/03/25. Record review of in-service training, dated 11/26-27/24, reflected all staff were in serviced on Abuse and Neglect. Record review of in-service training, dated 09/25/24, revealed all staff were trained on abuse neglect policy and procedure, resident assist x (0, 1, 2) status, [mechanical lift] policy and procedure, and reporting and removing of non-functioning equipment. Record review of Nursing Competency Evaluations was completed. Mechanical Lift Transfer competencies were completed between 09/25/2024 and 10/28/2024, with all direct care staff having completed a competency evaluation. Record review on 03/28/2025 of CNA Roster dated 03/28/2025 reflected Resident #1 was a 2 person transfer via mechanical lift. Interview on 03/27/2025 at 10:18 AM, CNA U stated she typically works from 6:00 AM until 2:00 PM, and that mechanical lifts always have to do 2 people. CNA U stated she regularly gets mechanical lift training, and has had one as recently as about a month ago. CNA U stated she has never seen anyone become injured during a mechanical lift, and if she ever saw another staff member doing a mechanical lift by herself she would contact her nurse, ADON, and DON. Interview on 03/27/2025 at 3:30 PM, LVN K stated she typically works from 8:00 AM until 5:00 PM, and the director of rehabilitation had trained staff on mechanical lifts after the incidents. LVN K stated she feels comfortable on how to use a mechanical lift and that training and competencies on mechanical lifts are done frequently. Interview on 03/27/2025 at 6:11 PM, CNA S stated he typically worked 10 PM until 6 AM and he recieved training on how to perform a mechanical lift last month. CNA S stated mechanical lifts must be done with 2 staff members and had never seen a 1 person mechanical lift. Interview on 03/27/2025 at 6:14 PM, CNA T stated they typically work 6:00 AM until 2:00 PM and had a mechanical lift training within the last month and that they have never seen a 1 person mechanical lift, as all mechanical lifts were completed with 2 people. (continued on next page)

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	675171	A. Building B. Wing	03/28/2025

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 03/28/2025 at 8:33 AM, CNA V stated they typically work 2:00 PM until 10:00 PM and had a mechanical lift training last month. CNA V was able to describe the different duties for each person during a mechanical lift, why it was imperative that the mechanical lift was done by 2 people, and that they had never seen a resident become injured during a mechanical lift. Interview on 03/28/25 at 09:30 AM, CNA Z, typically worked 2PM-10PM, revealed she was trained on transferring residents via mechanical lift and knew how to find out if a resident was transferred via mechanical lift, to include following therapy recommendations for residents. Interview on 03/28/25 at 02:15PM LVN C, typically worked 2PM-10PM, revealed she had been trained on how to do mechanical lifts and what residents were transferred via mechanical lifts. Interview on 03/28/2025 at 2:19 PM, CNA X stated she typically worked 6:00 AM until 2:00 PM, but will regularly pick up shifts at other times. CNA X stated that it is explicitly against policy to do a 1 person mechanical lift and that they had never seen a person become injured during a mechanical lift. Interview on 03/28/2025 at 2:22 PM, CNA Y stated that she works as needed and has worked all shifts, but primarily works between 6:00 AM until 2:00 PM, or 2:00 PM until 10:00 PM. CNA Y stated that she has extensive training on mechanical lifts and has been trained by the facility within the last few months. CNA Y stated she had never seen a person do a 1 person mechanical lift transfer at the present facility or at any facility she has worked at. CNA Y stated if she saw a staff member attempting to do a 1 person mechanical lift, she would step in to assist to ensure it became a 2 person mechanical lift transfer, and then report it to the DON. Interview on 03/28/25 on 02:33 PM, RN P revealed he worked all shifts and he was trained on how to use the mechanical lifts properly and knew where to look to identify if a resident required a mechanical lift for transfer. He also got this information from report from the previous nursing staff. Interview on 03/28/25 on 02:37 PM, CNA Q, typically worked 2PM-10PM, revealed she was trained on how to properly transfer residents with mechanical lifts (to include needing 2 people to transfer) and what residents needed to be transferred via mechanical lift. She was trained frequently about mechanical lifts with the last training being last month. Interview on 03/28/25 at 02:38PM, LVN R, typically worked the 8AM to 5PM shift, revealed she knew what residents were to be transferred via mechanical lift by looking at the Kardex or using CNA sheets at the nursing station. LVN R further revealed they needed 2 staff members to transfer residents via mechanical lift and she was trained frequently on using mechanical lifts. Facility policy titled, Safe Lifting and Movement of Residents, revised July 2017, reflected 1. Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regard the safe lifting and moving of residents . 3. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis .8. Mechanical lifts shall be made readily available and accessible to staff 24 hours a day. 10. Maintenance staff shall perform routine checks and maintenance of equipment used for lifting to ensure that it remains in good working order. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility policy titled, [Mechanical Lift] Policy, undated, reflected Every [mechanical lift] transfer requires 2 PERSON ASSIST for the safety of the resident and the staff members. The noncompliance was identified as PNC. The IJ began on 09/25/2024 and ended on 11/27/2024. The facility had corrected the noncompliance before the investigation began. The Administrator and the DON were notified on 03/28/2025 at 09:00 PM, a past non-compliance IJ situation had been identified due to the above failure.

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F 0839 Level of Harm - Potential for minimal harm Residents Affected - Many	Employ staff that are licensed, certified, or registered in accordance with state laws. 47564 Based on interview and record review, the facility failed to ensure professional staff were licensed, certified, or registered in accordance with applicable State laws for 1 of 12 staff (Respiratory Therapy Director) reviewed for staff qualifications. The facility failed to ensure the Respiratory Therapy Director, while working as a Respiratory Therapist, was licensed to practice as a respiratory therapist in the state of Texas from August 2021 to August 2024. This failure could place residents at risk of not receiving care and services from staff who were properly licensed. The findings included: Record review of the Respiratory Therapy Director's personnel file revealed a license from the National Board for Respiratory Care. The only state licensure available in the Respiratory Therapy Director's personnel file was beginning January of 2025. Further review of the personnel file revealed that the Respiratory Therapy Director worked at the facility as a Respiratory Therapist between the following dates: 08/20/2021 and 06/29/2022, 09/01/2022 and 08/15/2024. Interview on 03/28/2025 at 10:10 AM, the HR department head stated that there was no need to have the Respiratory Therapy Director's state licensure because his national licensure was in his personnel file. Record review of Texas Board of Respiratory Care Remedial Plan for the Respiratory Therapy Director, dated 02/06/2025, reflected that the Respiratory Therapy Director practiced without a license between August of 2021 and August of 2024. Record review of facility policy titled, Licensure, Certification, and Registration of Personnel, undated, reflected, Personnel undergoing a background investigation, if employed, will not be permitted to perform any duties that require a license/certification/registration until such investigation reveal a current unencumbered license/certification/registration.

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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** 45857 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 1 of 4 residents (Resident #2) reviewed for infection control: The facility failed to ensure CNA N and CNA O wore the proper PPE while transferring Resident #3 who was on EBP. These failures could place residents at-risk for infection due to improper care practices. The findings included: Record review of Resident #2's Face Sheet, dated 03/28/2025, reflected a [AGE] year-old female resident initially admitted to the facility on [DATE] with diagnoses of tracheostomy status (a hole that surgeons make through the front of the neck and into the windpipe, also known as the trachea. Surgeons place a tracheostomy tube into the hole to keep it open for breathing.), dependence on respirator [ventilator] status (machine or device used medically to support or replace the breathing of a person), diabetes mellitus (a group of diseases that result in too much sugar in the blood), dementia (a group of thinking and social symptoms that interferes with daily functioning), and quadriplegia (paralysis of all 4 limbs). Record review of Resident #2's Comprehensive Person-Centered Care Plan, undated, reflected I require assistance with my ADL's because I [sic] Diagnosis of: Quadriplegia with interventions to include, Transfer: I require total assistance in self performance with 2 person physical assistance staff support using a mechanical Hoyer lift. I require enhanced barrier precautions. Staff will doff/don PPE as needed per my EBP status. Record review of Resident #2's Quarterly MDS Assessment, dated 12/23/2024, reflected that Resident #2 required assistance with chair/bed-to-chair transfer and was Dependent on staff, meaning Helper does ALL the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Section O showed the resident required tracheostomy care and used an invasive mechanical ventilator. During an observation on 3/28/25 at 3:06 p.m. CNA O and CNA P transferred Resident #2 with a mechanical lift out of her bed and into a chair. Both had on gloves and no PPE gowns. During a joint interview on 3/28/25 at 3:15 p.m. CNA O and CNA P stated they were not aware if Resident #2 was on enhanced barrier precautions and thought the signage for EBP on the door and PPE hanging on the door might be for the roommate of Resident #2. CNA O stated a gown was required for resident on EBP to for safety from body fluids. CNA O and CNA P stated they had training over infection topics often. (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 3/28/25 at 6:53 p.m. the DON stated the CDC does not specifically state that a mechanical lift requires the use of a PPE gown for resident on EBP. The DON stated Resident #2 would be on EBP because of her tracheostomy. The DON stated she believed the MDROs precautions were out of control and unnecessary to use while transferring a residents. The DON stated there was a risk of transferring MDROs while transferring a resident, a risk of infection for the resident, and staff should wear a gown and gloves. Record review of the facility's policy titled Enhanced Barrier Precautions, dated 8/22, stated Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. Policy Interpretation and Implementation. 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi drug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care contact precautions do not otherwise apply. A. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room) .3. Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include .c. transferring .5. EBPs are indicated .for residents with .indwelling medical devices .