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	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rj Meridian Care of San Antonio	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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure residents had a right to personal privacy and confidentiality of his or her personal and medical records for 1 of 6 residents (Resident #4) reviewed for residents' rights. The facility failed to ensure LVN A locked the medication cart computer screen and left an unidentified resident's (Resident #4) information exposed. This failure could place residents at risk of resident-identifiable information being accessed by unauthorized persons. The findings included: Observation on 6/18/25 at 9:48 a.m. revealed a medication cart was left unlocked and unattended facing the hallway in the 200 hall and the computer screen on top of the medication cart counter was left opened with an Resident # 4's information exposed. Observation and interview on 6/18/25 at 9:49 a.m. revealed LVN A walked out of a resident room from across the hall on the 200 hall and walked up to the unlocked computer screen on top of the medication cart counter exposing an Resident # 4's information. LVN A stated, he had forgotten to lock the computer screen and leaving the computer screen open was a HIPAA violation and could result in an unauthorized person obtaining information from the resident and use their name fraudulently. During an interview on 6/18/25 at 4:13 p.m., the DON stated it was her expectation that staff locked the computer screens because exposed resident information was a HIPAA violation. The DON stated a resident's visible information could be used in the wrong way. Record review of the facility document titled, Resident Rights with revision date December 2016 revealed in part, .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to .The unauthorized release, access, or disclosure of resident information is prohibited .All .access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues. All inquiries concerning the release of resident information should be directed to the HIPAA Compliance Officer .

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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(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** Based on observation, 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 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 6 residents (Resident #1) reviewed for care plans: The facility failed to ensure Residents #1's comprehensive care plan reflected he received a mechanically altered diet. This deficient practice could cause confusion for staff members responsible for providing direct care to the residents and place residents at risk of receiving improper care and services. The findings included: Record review of Resident #1's face sheet dated 6/18/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included malignant neoplasm (cancer) of brain, hemiplegia (paralysis) affecting the left dominant side, and aphasia (language disorder that affects the ability to communicate usually caused by damage to the brain). Record review of Resident #1's most recent admission MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills, was dependent on staff with eating, and required a mechanically altered diet. Record review of Resident #1's Order Summary Report dated 6/18/25 revealed the following: - Regular diet MECHANICAL SOFT texture, REGULAR consistency, Double Portions, Mighty Shake TID. Serve liquid(s) in Adult Sip cup. Assist with Feedings; Encourage dining room feedings, with order date 4/30/25 and no end date. Record review of Resident #1's comprehensive care plan with review date 4/28/25 revealed the resident was at risk for aspiration due to swallowing difficulty and had a diet order for regular diet, pureed texture, with interventions to provide diet as ordered. During an observation on 6/18/25 at 12:11 p.m., Resident #1 was sitting in the dining room waiting on the lunch service. The ADON was observed serving Resident #1 his lunch and the meal ticket revealed the resident was supposed to receive a mechanical soft diet texture with regular consistency fluids, double portions, and a Mighty Shake, which the resident received. During an interview on 6/19/25 at 8:51 a.m., the DON stated Resident #1's care plan should have been updated to reflect the resident received a mechanical soft diet instead of puree. The DON stated the DM was in charge of updating the care plan for Resident #1. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/19/25 at 11:05 a.m., the DM stated he was routinely involved in care plan meetings and concentrated on discussions regarding a resident's diet. The DM stated he had updated Resident #1's meal ticket to reflect the resident received a mechanical soft diet but had never updated a care plan. The DM stated he was aware where to find a care plan but had never been told he needed to make dietary updates on the care plan. During an interview on 6/19/25 at 1:11 p.m., LVN B stated she had received a telephone order from Resident #1's physician on 4/30/25 to change the resident's diet order from puree to mechanical soft. LVN B stated she should have updated the care plan to reflect the diet change because she had taken the order from the physician. LVN B stated, MDS, Nursing, Dietary, Activities can all update the care plan for their specific discipline. LVN B stated the care plan was important because it reflected the type of care the resident should be getting or what needs to be done. During an interview on 6/20/25 at 9:59 a.m., the MDS Coordinator stated she was responsible for auditing resident care plans and was the gatekeeper for ensuring accuracy and updating pertinent information, such as medications, code status, and dietary changes. The MDS Coordinator stated she was not aware if the DM was supposed to update care plans based on his discipline. The MDS Coordinator stated the care plan was important because it painted a picture of the resident and helped staff as a guide to follow on how to take care of a resident. Record review of the facility document titled Care Plans, Comprehensive Person-Centered, with revision date December 2016 revealed in part, .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 .The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .The care planning process will .Include measurable objectives and timeframes .Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments to reflect the current condition for 1 of 6 residents (Resident #2) reviewed for care plan revisions. The facility failed to ensure Resident #2's care plan was comprehensive and updated to reflect Resident #2 had an indwelling catheter and a stage 4 pressure ulcer to the sacrum. This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs. The findings included: Record review of Resident #2's face sheet dated 6/20/25 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included severe protein-calorie malnutrition, heart failure, respiratory failure, dysphasia (medical condition characterized by a partial or total impairment of language ability that affects a person's ability to speak, understand spoken language, read, or write), kidney failure, and retention of urine. Record review of Resident #2's most recent admission MDS assessment dated [DATE] revealed the resident was cognitively intact for daily decision-making skills, utilized an indwelling urinary catheter, and had a stage 4 pressure ulcer. Record review of Resident #2's Order Summary Report dated 6/20/25 revealed the following: - CHANGE FOLEY CATHETER SECUREMENT DEVICE Q MONDAY AND PRN every night shift every Monday with order date 6/3/25 and no end date. - CHECK FOLEY CATHETER FOR SECUREMENT DEVICE AND PRIVACY BAG Q SHIFT - REPLACE AS NEEDED ever shift with order date 6/3/25 and no end date. - FOLEY CATHETER CARE Q SHIFT every shift with order date 6/3/25 and no end date. - MAY CHANGE FOLEY CATHETER AND BAG PRN as needed for occlusion or leakage with order date 6/3/25 and no end date - Wound care: Cleanse pressure wound of sacrum with wound cleaner, apply calcium alginate, and secure with bordered gauze island dressing, as needed for displacement/soilage with order date 6/5/25 and no end date. - Wound care: Cleanse pressure wound of sacrum with wound cleaner, apply calcium alginate, and secure with bordered gauze island dressing, for wound care with order date 6/5/25 and no end date. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's comprehensive care plan, undated, revealed the resident's use of an indwelling urinary catheter and the resident's stage 4 pressure wound to the sacrum was not included in the comprehensive care plan. During an interview on 6/20/25 at 9:59 a.m., the MDS Coordinator stated she was responsible for auditing resident care plans and was the gatekeeper for ensuring accuracy and updating pertinent information, such as medications, code status, and dietary changes. The MDS Coordinator stated the care plan was important because it painted a picture of the resident and helped staff as a guide to follow on how to take care of a resident. During wound care observation on 6/20/25 at 11:15 a.m., Resident #2 had an indwelling urinary catheter draining to gravity and a wound to the sacrum. Resident #2 stated he received wound care daily since his admission on [DATE]. During an interview on 6/20/25 at 12:11 p.m., the DON stated Resident #2's comprehensive care plan should have included the resident's wound and the indwelling urinary catheter. The DON stated she had planned on auditing care plans but had not gotten to it. The DON stated, since Resident #2 was newly admitted , and the admission MDS triggered the use of an indwelling catheter and the pressure wound, it should have been incorporated into the comprehensive care plan. The DON stated it was the responsibility of the MDS Coordinator to update the comprehensive care plan since Resident #2 was newly admitted . Record review of the facility document titled Care Plans, Comprehensive Person-Centered with revision date December 2016 revealed in part, .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 .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 .The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS) .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding for 1 of 1 resident (Resident #3) reviewed for enteral feeding: LVN C failed to flush Resident #3's enteral feeding tube per physician's orders. This deficient practice could place residents who received enteral nutrition and medications at increased risk of aspiration, infection, bloating discomfort, and not receiving the full benefit of the medications administered. The findings included: Record review of Resident #3's face sheet dated 6/19/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included pneumonitis due to inhalation of food and vomit, acute respiratory failure with hypoxia (deficiency of oxygen reaching the tissues of the body), gastroparesis (condition in which the stomach muscles do not function properly, causing delayed emptying of food from the stomach into the small intestine), and gastrostomy status (a surgical procedure in which a tube is inserted directly into the stomach through the abdominal wall to provide a way to deliver nutrition, fluids, or medications). Record review of Resident #3's most recent comprehensive MDS assessment dated [DATE] revealed the resident was severely cognitively impaired for daily decision-making skills and utilized an enteral feeding tube. Record review of Resident #3's Order Summary Report dated 6/19/25 revealed the following: - Change gtube [enteral feeding tube] spike set every change of formula and PRN every shift with order date 3/20/25 and no end date. - Flush Gtube [enteral feeding tube] with 30 ml of water before and after medication and 10 ml between medication every shift with order date 3/20/25 and no end date. Record review of Resident #3's comprehensive care plan with target date 9/25/25 revealed the resident utilized a feeding tube for nutritional needs and was at risk for aspiration and dehydration with interventions that included to provide water flushes per physician's orders and administer medications as ordered. Observation on 6/19/25 at 10:07 a.m., during the medication pass, revealed LVN C flushed Resident #3's enteral feeding tube with 10 ml of water prior to administering medications and then flushed the enteral feeding tube with 15 ml of water after medication administration instead of 30 ml per physician's orders. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/19/25 at 10:49 a.m., LVN C stated she forgot to flush Resident #3's enteral feeding tube with 30 ml of water before and after medication administration. LVN C stated she should have followed the physician's orders and not flushing the enteral feeding tube with enough water could result in the tube becoming clogged, and it could hurt the resident because of milking the tube. During an interview on 6/19/25 at 4:14 p.m., the DON stated the correct amount of flush administered to an enteral feeding tube was necessary to prevent the tube from clogging. The DON stated, if the (enteral feeding) tube clogs then medications could not be administered, and the enteral feeding tube would need to be replaced. Record review of the facility document titled Administering Medications through an Enteral Tube with revision date April 2018 revealed in part, .The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube .Administering each medication separately and flushing between medications is considered standard of practice .When the last of the medication begins to drain from the tubing, flush the tubing with 15 ml of warm water (or prescribed amount).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 2 of 2 medication carts reviewed for storage of drugs and biologicals. The facility failed to ensure the medication cart on 200 hall and 300 halls were locked and secured. These deficient practices could place residents at risk of medication misuse or drug diversion. The findings included: Observation on 6/18/25 9:48 a.m. revealed a medication cart was left unlocked and unattended facing the hallway in the 200 halls. Observation and interview on 6/18/25 at 9:49 a.m. revealed LVN A walked out of a resident room from across the hall on the 200 hall and walked up to the unlocked medication cart on the 200 hall. LVN A stated he was assigned to the medication cart on the 200 hall. LVN A stated he forgot to lock the medication cart and if unauthorized persons were to get into the medication cart, they could consume medications that did not belong to them and cause an allergic reaction. LVN A stated the medication cart should never be left unlocked and unattended. Observation on 6/19/25 at 10:07 a.m. revealed the medication cart on the 300 hall was left unlocked and unattended facing the hallway. Observation on 6/19/25 at 10:17 a.m. revealed the medication cart on the 300 hall was left unlocked and unattended facing the hallway. RT D (Respiratory Technician) was observed walking up to the medication cart on the 300 hall and locked it. During an interview on 6/19/25 at 10:49 a.m., LVN C stated, medication carts were never to be left unlocked and unsecured because somebody could have access to it, such as a resident, family member, or visitor and could take something they were not supposed to take. LVN C stated medication could be consumed that were not prescribed for them and could be used improperly. LVN C identified the medication cart on the 300 hall was assigned to RT D. During an interview on 6/19/25 at 10:56 a.m., RT D stated she believed she had forgotten to lock the medication cart assigned to her on the 300 hall and left it unlocked and unattended. RT D stated the medication cart was not supposed to be left unlocked and unattended because other people could have access to it and as you can see, we have a lot of breathing treatment medications. RT D stated the medication cart on the 300 hall was used for respiratory treatments and oxygen treatments and access to the breathing treatment medications by unauthorized persons could results in an allergic reaction and could affect their health. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/18/25 at 4:13 p.m., the DON stated it was her expectation the medication carts were supposed to be locked when not in use. The DON stated unauthorized persons could have access to medications that did not belong to them and cause them harm. The DON stated the facility had residents who wandered and could have access to the medications in an unlocked cart. During an interview on 6/19/25 at 1:11 p.m., LVN B, who stated she was also the Unit Manager stated medication carts, when not in use, were supposed to be locked. LVN B stated the facility had residents who wandered and if a medication cart was left unlocked and unattended, those residents who wandered could take medications from the unlocked cart and it was considered a safety issue. LVN B stated, the medications cart was supposed to be locked because residents can't be taking their own medications. During a follow up interview on 6/19/25 at 4:14 p.m., the DON stated, it was her expectation the medication carts were supposed to be locked when not in use. Record review of the facility document titled Security of Medication Cart with revision date April 2007 revealed in part, .The medication cart shall be secured during medication passes .The nurse must secure the medication cart during the medication pass to prevent unauthorized entry .Medication carats must be securely locked at all times when out of the nurse's view .

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide special eating equipment for residents who needed them and appropriate assistance to ensure that the resident could use the assistive devices when consuming meals for 1 of 1 resident (Resident #1) reviewed for special eating equipment and assistance when consuming meals. The facility failed to ensure Resident #1 was provided with an Adult Sip Cup to meet Resident #1's need for assistance while eating. This failure could place residents at risk for harm from weight loss, diminished independence, and self-esteem. The findings included: Record review of Resident #1's face sheet dated 6/18/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included malignant neoplasm (cancer) of brain, hemiplegia (paralysis) affecting the left dominant side, and aphasia (language disorder that affects the ability to communicate usually caused by damage to the brain). Record review of Resident #1's most recent admission MDS assessment dated [DATE] revealed the resident was moderately cognitively impaired for daily decision-making skills, was dependent on staff with eating, and required a mechanically altered diet. Record review of Resident #1's Order Summary Report dated 6/18/25 revealed the following: - Regular diet MECHANICAL SOFT texture, REGULAR consistency, Double Portions, Mighty Shake TID. Serve liquid(s) in Adult Sip cup. Asst w/Feedings; Encourage dining room feedings. Record review of Resident #1's comprehensive care plan with review date 4/28/25 revealed the resident was at nutritional risk secondary to cognitive impairment with interventions that included to provide adaptive feeding equipment as needed. Observation and interview on 6/18/25 at 12:11 p.m. revealed Resident #1 sitting in the dining room awaiting the lunch service. An unidentified staff was observed leaving two cups of a beverage on the resident's table. Resident #1 was observed taking a cup with the beverage and was observed attempting to drink from it from the left side of his mouth. Resident #1 was observed spilling most of the beverage onto himself. Resident #1 nodded and gave a thumbs up when asked if he was drinking tea. Resident #1 continued to attempt to drink from the cup and was observed spilling it. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 6/18/25 at 12:22 p.m., the ADON delivered the lunch tray to Resident #1 and the Adult Sip Cup was observed on the lunch tray. The ADON opened the resident's milk shake and poured the contents of it into the Adult Sip Cup. Resident #1 took the Adult Sip Cup with the milk shake and began to drink from it. The ADON stated she was unsure if Resident #1 could consume beverages from regular cups and as far as she knew the only reason Resident #1 could not use the regular cups was because of dexterity. The ADON stated the resident was not at risk for aspiration and just had a history of seizures. An unidentified kitchen staff was then observed providing two Adult Sip Cups to the resident with water and tea. During an interview on 6/18/25 at 12:31 p.m., the DM stated Resident #1's meal ticket indicated the resident could have one beverage with the Adult Sip Cup, but beverages were offered by the floor staff. The DM stated, if the resident wanted another type or beverage, or more, the floor staff should be letting the kitchen staff know Resident #1 needed an Adult Sip Cup. The DM stated, when the lunch trays were assembled, there were three checks. The DM stated, one aide makes sure there are condiments and desserts; when it comes to the end of the line, we have another aide to make sure the texture is correct and checks for preferences or dislikes, and then we load them up in the carts for the halls. The DM stated, kitchen staff did not load up dining room trays until the nursing staff were in the dining room. The DM stated, I know what's on the ticket, he (Resident #1) needs the Adult Sip Cup to help him from spilling the beverage and it has a controlled flow, so he does not choke. During an interview on 6/18/25 at 12:37 p.m., CNA E stated, as far as she knew, Resident #1 was supposed to have an Adult Sip Cup and was not supposed to have a regular cup because the resident was unable to drink from a regular cup because of spillage. CNA E stated, the Adult Sip Cup was supposed to help to prevent Resident #1 from choking and stated, it's not like there is a shortage of sip cups. During an interview on 6/18/25 at 4:13 p.m., the DON stated, Resident #1 was supposed to be provided with an Adult Sip Cup to consume beverages and the use of the adaptive equipment was to prevent aspiration and dehydration. Record review of the facility document titled, Assistance with Meals with revision date March 2022 revealed in part, .Resident shall receive assistance with meals in a manner that meets the individual needs of each resident .Residents Who May Benefit from Assistive Devices .Adaptive devices (special eating equipment and utensils) will be provided from residents who need or request them. These may include devices such as . specialized cups .Assistance will be provided to ensure than (sic) residents can use and benefit from special eating equipment and utensils .