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	07/18/2025

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

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025

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

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's right to be informed and make treatment decisions for 2 of 23 residents (Resident# 2 and Resident #82) reviewed, in that: Resident's #2 and #82 did not sign their own consent forms to receive psychoactive medications. This deficient practice could result in residents receiving medications and treatments for which they have not given informed consent. The findings were: Record review of Resident #2's face sheet, dated 07/18/2025, revealed the resident was admitted to the facility on [DATE] with diagnoses including: Other Schizoaffective Disorders, Adjustment Disorder with Anxiety, Type 2 Diabetes Mellitus Without Complications. Record review of Resident #2's Quarterly MDS, dated [DATE], revealed a BIMS score of 12 which indicated moderate cognitive impairment. Record review of Resident #2's care plan, no revision date, revealed, At risk for side effects R/T use of psychotropic medication for dx: schizophrenia. Further review revealed, I am at risk for side effects due to use of antidepressant medication r/t dx of depression and I use psychotropic medications -antipsychotic meds -antidepressant meds with an intervention, Staff to acquire consent prior to administering medication. Record review of Resident #2's order summary as of 07/18/2025, revealed Depakote Oral Tablet Delayed Release 250 MG (Divalproex Sodium) Give 1 tablet by mouth two times a day for MOOD order date 03/21/2025, SEROquel Oral Tablet 400 MG (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime for SCHIZOPHRENIA order date 03/28/2025 and Sertraline HCl Tablet 100 MG Give 2 tablet by mouth one time a day for DEPRESSION 2 tabs to equal 200mg order date 05/05/2025. Record review of Resident #2's clinical record as of 07/18/2025, revealed Psychoactive Medication Therapy Informed Consent Form, dated 01/27/2025, to receive the medication Sertraline for depression which was signed by the resident's representative instead of the resident. Record review of Resident #2's clinical record as of 07/18/2025, revealed Psychoactive Medication Therapy Informed Consent Form, dated 03/21/2025, to receive the medication Xanax for anxiety which was signed by the resident's representative instead of the resident. Record review of Resident #2's clinical record as of 07/18/2025, revealed Psychoactive Medication Therapy Informed Consent Form, dated 03/02/2025, to receive the medication Alprazoiam for anxiety which was signed by the resident's representative instead of the resident. Record review of Resident #2's clinical record as of 07/18/2025, revealed Psychoactive Medication Therapy Informed Consent Form, dated 03/21/2025, to receive the medication Zoloft for depression which was signed by the resident's representative instead of the resident. Record review of Resident #2's clinical record as of 07/18/2025, revealed Psychoactive Medication Therapy Informed Consent Form, dated 03/21/2025, to receive the medication Seroquel for schizophrenia which was signed by the resident's representative instead of the resident. Record review of Resident #82's face sheet, dated 07/18/2025, revealed he was admitted on [DATE] with diagnoses including Generalized Anxiety Disorder, Anemia, and Type 2 Diabetes Mellitus. Record review of Resident #82's admission MDS, dated [DATE], revealed a BIMS score of 14 which indicated intact cognition. Record review of Resident #82's care plan, no revision date, revealed, I have episodes of Anxiety busPIRone HCl hydrOXYzine HCl; I am taking OLANZapine for episodes of Agitation; I am taking Divalproex Sodium for the treatment for mood; At risk for side effects R/T use of psychotropic medication Olanzapine dx: agitation.Record review of Resident #82's clinical record as of 07/18/2025, revealed Psychoactive Medication Therapy Informed Consent Form, dated 06/24/2025, to receive the medication Divalproex for mood disorder which was signed by the resident's representative instead of the resident. Record review of Resident #82's clinical record as of 07/18/2025, revealed Psychoactive Medication Therapy Informed Consent Form, dated 06/24/2025, to receive the medication Buspirone for anxiety which was signed by the resident's representative instead of the resident. Record review of Resident #82's clinical record as of 07/18/2025, revealed Psychoactive Medication Therapy Informed Consent Form, dated 06/24/2025, to receive the medication Olazapine for agitation which was signed by the resident's representative instead of the resident. Record review of Resident #82's clinical record as of 07/18/2025, revealed Psychoactive Medication Therapy Informed Consent Form, dated 06/24/2025, to receive the medication Hydroxyzine for anxiety which was signed by the resident's representative instead of the resident. Record review of Resident #82's clinical record as of 07/18/2025, revealed Psychoactive Medication Therapy Informed Consent Form, dated 06/24/2025, to receive the medication Xanax for anxiety which was signed by the resident's representative instead of the resident. Record review of Resident #82's clinical record as of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER: Rj Meridian Care of San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 6 residents out of 18 residents (Resident #3, Resident #4, Resident #8, Resident #7, Resident #11, and Resident #55) whose records were reviewed for assessments. 1. The nursing facility did not identify siderails were used as a restraint for Resident #32. The nursing facility did not identify siderails were used as a restraint for Resident #43. The nursing facility did not identify siderails were used as a restraint for Resident #74. The nursing facility did not identify siderails were used as a restraint for Resident #85. Resident #11's quarterly MDS, dated [DATE], inaccurately revealed the resident was receiving hospice care. 6. Resident #55's quarterly MDS, dated [DATE], inaccurately revealed the resident did not have surgical wound. This deficient practice could affect any resident and could result in the inaccurate status of the residents. The findings were: 1. Review of Resident #3's face sheet, dated 7/18/25, revealed he was admitted to the facility on [DATE] with diagnoses including Dementia in other diseases classified, severe and Acute and chronic respiratory failure with hypoxia[JM1] (low levels of oxygen in the body tissues). Review of Resident #3's annual MDS assessment, dated 5/9/25, revealed his BIMS score was 3 indicative of severe cognitive impairment and he had impaired range of motion on both lower extremities. Further review revealed the use of side rails was not identified as a restraint. Review of Resident #3's CP, revised 6/23/25, revealed he required total assistance by 1-2 persons with mobility. Further review revealed Resident #3 had established contractures of bilateral lower and upper extremities due to impaired mobility (upon admission). Review of Resident #3's ADL flowsheet from 7/4/25 to 7/17/25: Self-performance: How resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture revealed he required extensive assistance on a couple of days and total assistance on most days. Review of Resident #3’s consolidated physician orders for July 2025 revealed a side rail order “MAY HAVE 1/4 SIDE RAILS UP AS NEEDED FOR ENABLER Phone Active 05/19/2025.” Observation on 07/16/2025 at 10:16 AM revealed Resident #3 was lying in bed with padded 1/4 side rails on both sides of the bed. The side rails were up and locked and he also had mittens on both hands. Interview on 07/17/25 at 2:05 PM with LVN I revealed Resident #3 was totally dependent on staff for all ADL's and was not able to use the side rails for mobility especially since he wore mittens on both hands. She stated the side rails kept Resident #3 from pulling on his trachea which he would often do if he did not have mittens on. LVN I stated the side rails were used for safety because he would move throughout the bed and was a fall risk. She further stated the side rails kept him from falling out of bed. Interview on 07/17/25 at 2:10 PM with CNA H and CNA E revealed Resident #3 did not use the side rails for mobility. They stated the side rails kept him from falling out of bed because he would move all around his bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Rj Meridian Care of San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 07/18/25 at 10:08 AM with the DON revealed Resident #3 was totally dependent on staff for all ADL's and did not use the side rails for mobility. She stated the side rails were used for safety to prevent falls since they were implemented. She stated they were in fact used as restraints.[JM2] [DG3] The DON stated the facility had flagged for restraints, but they did not have an MDS staff to update the MDS assessment. The DON stated it was necessary for the MDS assessment to adequately represent the resident's needs and overall status; otherwise, the result could be that the resident did not receive the necessary care and services as needed. 2. Review of Resident #4's face sheet, dated 7/18/25, revealed he was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction (stroke), undifferentiated Schizophrenia and Generalized Anxiety. Review of Resident #4's annual MDS assessment, dated 5/7/25, revealed his BIMS score was 3 indicative of severe cognitive impairment and he had impaired range of motion on both upper and lower extremities. Further review revealed the use of side rails were not identified as restraint use. Review of Resident #4's CP revised on 7/5/25 revealed he required assistance with ADL's due to respiratory failure, muscle wasting and atrophy, unspecified lack of coordination, CVA, cognitive deficit. One of the interventions included Resident #3 required 2- person assistance with bed mobility. Review of Resident #4’s consolidated physician orders revealed an order for side rails, “MAY HAVE 1/4 SIDE RAILS UP AS NEEDED FOR ENABLER Phone Active 04/30/2025.” Observation on 07/16/2025 at 10:33 AM revealed Resident #4 lying in bed asleep, bed was in the low position with padded 1/4 side rails up and locked on both sides. There were mats on the floor on both sides of the bed, wedge bolsters towards the foot of the bed along both sides of the mattress and there was a pillow between the side rail and left shoulder. Resident #4 had socks on both hands. Interview on 07/17/25 at 2:05 PM with LVN I revealed Resident #4 was totally dependent on staff for all ADL's and did not use the side rails for mobility. She stated he was not able to use the side rails for mobility especially since he wore mittens or gloves on both hands. She stated the side rails kept Resident #4 from pulling on his trachea which he would often do if he did not have mittens or gloves on. LVN I stated the side rails were used for safety because he would move throughout the bed and was a fall risk. She further stated the side rails kept him from falling out of bed. Interview on 07/17/25 at 2:10 PM with CNA H and CNA E revealed Resident #4 did not use the side rails for mobility. They stated the side rails kept him from falling out of bed because he would move all around his bed. Interview on 07/18/25 at 10:08 AM with the DON revealed Resident #4 was totally dependent on staff for all ADL's and did not use the side rails for mobility. She stated the side rails were used for safety to prevent falls since they were implemented. She stated they were in fact used as restraints. The DON stated the facility had flagged for restraints, but they did not have an MDS staff to update the MDS assessment. The DON stated it was necessary for the MDS assessment to adequately represent the resident's needs and overall status; otherwise, the result could be that the resident did not receive the necessary care and services as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Rj Meridian Care of San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of Resident #7's face sheet, dated 7/18/25, revealed she was admitted to the facility on [DATE] with diagnoses including Diffuse traumatic brain injury (happens when a sudden, external, physical assault damages the brain) and contracture joint. Review of Resident #7's MDS assessment, dated 5/30/25, revealed her BIMS score was 6 indicative of severe cognitive impairment. Resident had impaired range of motion on both upper and lower extremities and was dependent on staff for all ADL care including bed mobility. Interview on 07/17/25 at 2:05 PM with LVN I revealed Resident #7 was totally dependent on staff for all ADL's and was not able to use the side rails for mobility because both her hands were contracted. LVN stated the siderails were used for safety to ensure she did not fall out of bed. Observation on 07/16/2025 at 10:46 AM revealed Resident #7 lying in bed asleep with HOB up about 30 degrees. Resident #7's had contractures on both wrists/hands and ¼ side rails were up and locked on both sides of the bed. Interview on 07/17/25 at 2:10 PM with CNA H and CNA E revealed Resident #7 was not able to use the side rails for mobility because of the contractures on her hands. They stated the side rails were used for safety to prevent falls. Interview on 07/18/25 at 10:08 AM with the DON revealed Resident #7 was totally dependent on staff for all ADL's and did not use the side rails for mobility. She stated the side rails were used for safety to prevent falls since they were implemented. She stated they were in fact used as restraints. The DON stated the facility had flagged for restraints, but they did not have an MDS staff to update the MDS assessment. The DON stated it was necessary for the MDS assessment to adequately represent the resident's needs and overall status; otherwise, the result could be that the resident did not receive the necessary care and services as needed. 4. Review of Resident #8's face sheet, dated 7/18/25, revealed she was admitted to the facility on [DATE] with diagnosis to include Anoxic Brain Damage. Review of Resident #8's quarterly MDS assessment, dated, 6/28/25 revealed her BIMS score was coded as severe cognitive impairment and she had impaired range of motion on both upper extremities. Further review revealed the use of side rails were identified as restraint “used less than daily”. Review of Resident #8's CP revised on revealed she required total assistance with ADL's due to Anoxic Brain Injury. One of the interventions included Resident #8 required total assistance by 2- persons with bed mobility. Observation and attempted interview on 07/16/25 at 9:52 AM revealed Resident #8 was lying in bed with 1/4 side rails up and locked on both sides of the bed. Resident #8 had contractures on both wrists/hands. Resident #8 would move her eyes when spoken to but was non-verbal. Interview on 07/17/25 at 2:05 PM with LVN I revealed Resident #8 was totally dependent on staff for all ADL's and was not able to use the side rails for mobility because she had contractures on both hands. LVN I stated the siderails were used daily for safety to ensure Resident #8 did not fall out of bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Rj Meridian Care of San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 07/17/25 at 2:10 PM with CNA H and CNA E revealed Resident #4 did not use the side rails daily for mobility because she had contractures on both hands. They stated the side rails were used for safety so that she did not fall out of bed. Interview on 07/18/25 at 10:08 AM with the DON revealed Resident #8 was totally dependent on staff for all ADL's and did not use the side rails for mobility. She stated the side rails were used for safety to prevent falls since they were implemented. She stated they were in fact used as restraints. The DON stated the facility had flagged for restraints, but they did not have an MDS staff to update the MDS assessment. The DON stated it was necessary for the MDS assessment to adequately represent the resident's needs and overall status; otherwise, the result could be that the resident did not receive the necessary care and services as needed. 5. Record review of Resident #11's face sheet, dated 07/18/2025, revealed the resident was [AGE] years old male and admitted to the facility on [DATE] with diagnoses of open-angle glaucoma (increased pressure inside eyes, potentially optic nerve damage and vision loss), type 2 diabetes mellitus (the body has trouble controlling blood sugar and using it for energy), cerebral infarction (area of brain tissue that dies as a result of localized low oxygen due to cessation of blood flow), chronic kidney disease-stage 3 (kidneys are less able to filter water and fluid out of the body), and hemiplegia and hemiparesis (weakness on one side of your body). Record review of Resident #11’s quarterly MDS, dated [DATE], revealed the resident's BIMS score was 14 out of 15, which indicated the resident's cognitive was intact, and in Section O (Special Treatment), it was coded that Resident #11 was receiving hospice care. However, the answer regarding “Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?) was coded “No,” instead of “Yes” in Section J (Health Conditions). Record review of Resident #11's comprehensive care plan, dated 02/28/2025, revealed The resident received hospice care related to chronic kidney disease - For intervention: coordinate care with hospice care and hospice care program as ordered. Record review of Resident #11’s Physician Certification of Terminal Illness, dated 02/28/2025, revealed hospice physician said, “I certify that I am a physician licensed in the State of Texas or a physician on duty with the United State military and that the recipient identified above is terminally ill with a medical prognosis of six months or less to live if the illness runs its normal course.” Interview on 07/18/2025 at 8:42 a.m. with DON stated because Resident #11 was receiving hospice are, Yes should have been coded to the answer regarding “Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?) of the resident's quarterly MDS, dated [DATE], instead of No. DON said it was mistake, coding accurately was a MDS nurse's responsibility, and inaccurate MDS assessment might affect improper care to Resident #11. Further interview with DON said the facility did not have MDS nurse, so the company MDS nurse was helping, but the nurse was on vacation at this time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Rj Meridian Care of San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Record review of Resident #55's face sheet, dated 07/18/2025, revealed the resident was [AGE] years old male and admitted to the facility originally on 11/14/2024 and re-admitted on [DATE] with diagnoses of dry eye syndrome bilateral lacrimal glands (inflammation of the tear-shaped gland), fatty liver (fat builds up in the liver), paraplegia (loss of muscle function in the lower half of the body), hypertension (high blood pressure), and dysuria (the sensation of pain or burning when urination). Record review of Resident #55’s quarterly MDS, dated [DATE], revealed the resident's BIMS score was 13 out of 15, which indicated the resident's cognitive was intact, and in Section M (Skin Conditions), the resident’s surgical wound was coded “No.” Record review of Resident #55's comprehensive care plan, dated 05/15/2025, revealed the resident has current surgical wound that require treatment to his left groin. For intervention – Treatment per medical doctor’s orders. Record review of Resident #55’s physician order, dated 06/26/2025, revealed “wound care: Clean left groin post-surgical wound with ¼ strength Dakins, pat dry, apply calcium alginate, dry dressing daily and as needed.” Record review of Resident #55’s weekly sin assessment, dated 05/12/2025, revealed the resident had post-surgical wound of the left groin with no signs of infection. Interview on 07/18/2025 at 9:00 a.m. with Resident #55 refused interview with the surveyor, and the surveyor to observe his wound and wound care. Interview on 07/18/2025 at 9:21 a.m. with DON stated Resident #55 was receiving wound care currently because the resident had post-surgical wound to his groin, so the resident MDS, dated [DATE] regarding the resident’s surgical wound was coded “No” was inaccurate. It should have been coded “Yes.” DON said it was mistake, coding accurately was a MDS nurse's responsibility, and inaccurate MDS assessment might affect improper care to Resident #55. Further interview with DON said the facility did not have MDS nurse, so the company MDS nurse was helping, but the nurse was on vacation at this time. Record review of the facility policy, titled Resident Assessment, revised 03/2022, revealed . 7. All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.

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	07/18/2025

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

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to refer all residents to PASARR with newly evident or possible serious mental disorder for level II resident review for 1 of 6 Residents (Resident #4) whose records were reviewed for PASARR assessments. The facility failed to refer Resident #4 for PASARR (Preadmission Screening and Resident Review) Level II comprehensive evaluation when Resident #4 was diagnosed with Major Depressive Disorder (causes a persistently low or depressed mood and a loss of interest in activities that you used to enjoy) on 4/1/23 and undifferentiated Schizophrenia (serious mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior) on 2/16/24. This deficient practice could affect residents diagnosed with mental disorders and could result in the residents not receiving the necessary services from PASARR.The findings were:Based on interview and record review the facility failed to refer all residents to PASARR (Preadmission Screening and Review) with newly evident or possible serious mental disorder for level II resident review for 1 of 6 Residents (Resident #4) whose records were reviewed for PASARR assessments. The facility failed to refer Resident #4 for PASARR Level II comprehensive evaluation when Resident #4 was diagnosed with Major Depressive Disorder (causes a persistently low or depressed mood and a loss of interest in activities that you used to enjoy) on 4/1/23 and undifferentiated Schizophrenia (serious mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior) on 2/16/24. This deficient practice could affect residents diagnosed with mental disorders and could result in the residents not receiving the necessary services from PASARR. The findings were: Review of Resident #4's face sheet, dated 7/18/25, revealed he was admitted to the facility on [DATE] with diagnoses including Major Depressive Disorder (causes a persistently low or depressed mood and a loss of interest in activities that you used to enjoy) and undifferentiated Schizophrenia (serious mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior) and Generalized Anxiety. Further review revealed Resident #4 did not have a diagnosis of Dementia (loss of cognitive functioning it interferes with a person's daily life and activities). Review of Resident #4's annual MDS assessment, dated 5/7/25, revealed his BIMS score was 3 of 10 indicative of severe cognitive impairment. Further review revealed he had diagnoses including Anxiety, Depression and Schizophrenia (serious mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior). Review of Resident #4's CP revised on 7/5/25 revealed he used psychotropic medications and was receiving psychological, psychiatry services for visits, and medication management. Review of Resident #4's consolidated physician orders for July 2025 revealed he was receiving Escitalopram Oxalate Oral Tablet 10 MG (Escitalopram Oxalate) Give 1 tablet via PEG-Tube one time a day for DEPRESSION. Start date was 5/01/2025. Review of Resident #4's PASRR Level 1 Screening, dated 8/25/22, revealed he did not meet the criteria for mental illness. Interview on 7/18/25 at 4:45 PM with the DON revealed Resident #4 did not have diagnosis of Dementia and was diagnosed with Major Depressive Disorder and Schizophrenia after being admitted to the facility. The DON stated usually the MDS Coordinator was responsible for referring residents for PASARR services, but that position was vacant. She stated he should have been referred to PASARR for evaluation to determine if he met the criteria for mental illness. The DON stated if he did, he would receive services which could improve his quality of life. Otherwise, he could suffer a decline in mental condition. The DON was asked for a PASARR policy on 7/18/25 at 4:45 PM and did not provide one by the end of the survey on 7/18/25 at 11:30 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025

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

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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Rj Meridian Care of San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	**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 that included measurable objectives and timeframes to meet a resident's medical, nursing, and psychosocial needs for 3 of 6 Residents (Resident #3, Resident #4 and Resident #7) whose Care Plans were reviewed. The facility failed to recognize Resident #3 used 1/4 side rails as a restraint and failed to implement interventions to ensure his safety.The facility failed to include Resident #4 used 1/4 side rails while in bed, that they were used as a restraint and failed to develop/implement interventions to ensure his safety.The facility failed to develop and implement interventions related to the fact Resident #7 had contractures on both wrists/hands and she used side rails while in bed. These failures could place residents at risk for not getting their medical, physical, and psychosocial needs met and not being provided with the necessary care or services and having personalized plans developed to address their specific needs. The findings were:Review of Resident #3's face sheet, dated 7/18/25, revealed he was admitted to the facility on [DATE] with diagnoses including Dementia (loss of cognitive functioning it interferes with a person's daily life and activities) in other diseases classified, severe and Acute and chronic respiratory failure with hypoxia (low oxygen levels). Review of Resident #3's annual MDS assessment, dated 5/9/25, revealed his BIMS score was 3 of 10 indicative of severe cognitive impairment and he had impaired range of motion on both lower extremities. Review of Resident #3's CP, completed on 6/23/25, revealed he required total assistance by 1-2 persons with mobility, he had established contractures of bilateral lower and upper extremities due to impaired mobility (upon admission). Further review revealed he used side rails for positioning while in bed. The CP did not identify the side rails were used as a restraint. Review of Resident #3's consolidated physician orders for July 2025 revealed a side rail order MAY HAVE 1/4 SIDE RAILS UP AS NEEDED FOR ENABLER Phone Active 05/19/2025. Observation on 07/16/2025 at 10:16 AM revealed Resident #3 was lying in bed with padded 1/4 side rails on both sides of the bed. The side rails were up and locked and he also had mittens on both hands. Interview on 07/17/25 at 2:05 PM with LVN I revealed Resident #3 was totally dependent on staff for all ADLs. LVN I stated the side rails were used for safety because he would move throughout the bed and was a fall risk. She further stated the side rails kept him from falling out of bed. Interview on 07/17/25 at 2:10 PM with CNA H and CNA E revealed Resident #3 used side rails to keep him from falling out of bed because he would move all around his bed. Interview on 07/18/25 at 10:08 AM with the DON revealed Resident #3 was totally dependent on staff for all ADLs. She stated the side rails were used for safety to prevent falls since they were implemented. She stated they were in fact used as restraints. The DON stated the facility had flagged for restraints, but they did not have an MDS Coordinator who also completed Care Plans. She stated the unit mangers/ADON's were responsible to ensure they were compliant. The DON stated the use of side rails should be identified as restraint use along with implementation of interventions in the CP. She stated this was necessary so that staff was aware to monitor the resident's safety and report any adverse effects. Otherwise, it could result in the resident being injured. 2. Review of Resident #4's face sheet, dated 7/18/25, revealed he was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction (stroke), undifferentiated Schizophrenia (serious mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior) and Generalized Anxiety. Review of Resident #4's annual MDS assessment, dated 5/7/25, revealed his BIMS score was 3 of 10 indicative of severe cognitive impairment and he had impaired range of motion on both upper and lower extremities. Review of Resident #4's CP completed on 7/5/25 revealed it did not address the use of bilateral 1/4 side rails while in bed and that they were used as a restraint. Review of Resident #4's consolidated physician orders revealed an order for side rails, MAY HAVE 1/4 SIDE RAILS UP AS NEEDED FOR ENABLER Phone Active 04/30/2025. Observation on 07/16/2025 at 10:33 AM revealed Resident #4 lying in bed asleep, bed was in the low position with padded 1/4 side rails up and locked on both sides. Interview on 07/17/25 at 2:05 PM with LVN I revealed Resident #4 was totally dependent on staff for all ADLs. LVN I stated the side rails were used for safety because he would move throughout the bed and was a fall risk. She further stated the side rails kept him from falling out of bed. Interview on 07/17/25 at 2:10 PM with CNA H and CNA E revealed Resident #4 used side rails to keep him from falling out of bed because he would move all around his bed. Interview on 07/18/25 at 10:08 AM with the DON revealed Resident #4 used

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Rj Meridian Care of San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 interviews and record review, the facility failed to review and revise resident care plans after each assessment for 1 of 18 residents (Resident #55) reviewed for care plan revision/timing. The facility failed to ensure Resident #55's care plan addressed changes in his smoking status regarding the resident could keep his cigarettes and lighter because he was very safe smoker after smoking assessment, dated 05/08/2025. This deficient practice could affect residents' care and services and may cause a delay in treatment and/or decline in health. Findings included:Record review of Resident #55's face sheet, dated 07/18/2025, revealed the resident was [AGE] years old male and admitted to the facility originally on 11/14/2024 and re-admitted on [DATE] with diagnoses of dry eye syndrome bilateral lacrimal glands (inflammation of the tear-shaped gland), fatty liver (fat builds up in the liver), paraplegia (loss of muscle function in the lower half of the body), hypertension (high blood pressure), and dysuria (the sensation of pain or burning when urination). Record review of Resident #55's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 13 out of 15, which indicated the resident's cognitive was intact, and the resident required substantial/maximal assistant (Helper does more than half the effort) to chair to bed transfer and sit to stand. Record review of Resident #55's comprehensive care plan, dated 05/15/2025, revealed the resident is a smoker. For interventions - all cigarettes and lighter must be stored in med room and smoking assessment per social worker. Smoking in designated area only. Record review of Resident #55's smoking assessment, dated 05/08/2025, revealed The resident may smoke independently, smoke unsupervised in designated smoking area, and have been informed of smoking policies and procedures - Plan of care should be updated. Attempted interview on 07/18/2025 at 9:00 a.m. with Resident #55 revealed he refused the interview with the surveyor. Interview on 07/18/2025 at 9:21 a.m. with DON stated Resident #55 could keep his cigarettes and disposable lighter per the facility policy because he was safe and independent smoker after the smoking assessment, dated 05/08/2025. The current care plan was incorrect, and it should have been updated and revised after smoking assessment (dated 05/08/2025). The DON stated updating and revising care plan was MDS nurse's responsibility, but the facility did not have MDS nurse, so the company MDS nurse was helping, but the nurse was on vacation at this time. That might cause not updating care plans, and not updating care plan might cause improper care to the resident. Record review of the facility smoking policies, revised 08/2022, revealed . 12. Residents who have independent smoking privileges are permitted to keep cigarettes, electronic-cigarettes, pipes, tobacco, and other smoking items in their possession. Only disposable safety lighters are permitted. All others of lighters, including matches, are prohibited.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025

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

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that residents received proper treatment and good foot health in accordance with professional standards of practice, including to prevent complications from the resident's medical condition for 1 of 1 Resident (Resident #9) whose records were reviewed for assessments. LVN/Treatment Nurse K failed to assess Resident #34's feet during a head-to-toe assessment and did not identify he had significantly long toenails and two ingrown toenails. This deficient practice could affect any resident and could contribute to pain, infections and loss of toes. The findings were:Review of Resident #9's face sheet, dated 7/17/25, revealed he was admitted to the facility on [DATE] with diagnosis including Critical Illness Myopathy (generalized weakness involving the muscles of the extremities, trunk, and respiration that frequently occurs in conjunction with severe illness and is associated with significant morbidity and mortality). Review of Resident #9's admission MDS assessment, dated 4/6/25, revealed his BIMS score was 15 of 15 reflective of not having impaired cognition and he did not have foot problems. Review of Resident #9's CP, dated 7/14/25, revealed he was at risk for skin breakdown and I am at risk for new pressure ulcers due to my impaired mobility and one of the interventions included Weekly Skin Assessment. Notify MD and Family of any skin breakdown or skin problems. Review of Resident #9's admission Nursing Assessment, dated 4/1/25, including an assessment of his feet, did not reveal any skin problems. Interview on 7/17/25 at 1:49 PM of Resident #9 revealed he was lying in bed. Resident #9 stated his feet hurt related to ingrown toenails. Resident's voice was faint and difficult to hear but also communicated with a communication board. Resident #9 stated he let nursing staff know about it since admission and stated he was waiting for staff to address the issue. Interview on 7/17/25 at 4:35 PM with LVN L, charge nurse revealed she was not aware of Resident #9 having any problems with his feet. Observation and interview on 7/17/25 at 5:13 PM with the DON and Resident #9 revealed she assessed Resident #9's feet. The DON stated his feet were scaly and dry and all of his toenails were long. She stated his toenails needed to be cut. The DON stated his left great toenail was significantly long and looked like it was ingrown. His great toenail was approximately 1 inch past his nail bed and there were red spots on the corners of the nail. The DON stated the right toenail on the 4th toe was curled over and under his toe. She stated the right great toenail also appeared to be ingrown. Resident #9 stated his toes hurt when he wore shoes. The DON stated the treatment nurse completed weekly skin assessments and should have seen the condition of his toenails. She stated the CNA's should also be completing any skin problems on Resident's shower sheets. The DON stated the result of Resident #9 not receiving care could lead to skin infections, other ingrown toenails and loss of toes. Interview on 7/18/25 at 9:55 AM with LVN/Treatment Nurse K revealed she had assumed her position about two months ago during May 2025. She stated she was responsible for completing weekly skin assessments on all residents and had completed assessments for Resident #9. She stated she had been focused on developing a system to ensure she completed all resident assessments. LVN K stated she did not remember assessing Resident #9's feet but it was part of the assessment and should have capture the condition of his feet. She stated she had been focused on developing a system to ensure she completed all resident assessments. LVN K stated not assessing Resident #9's delayed care, could cause infections and a decline in his overall physical health. Review of facility policy, Resident Examination and Assessment, revised 2014 read in relevant part, The purpose of this procedure is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan. Physical Exam 8. Skin: a. intactness; b. moisture; c. color; d. texture; and presence of bruises, pressure sores, redness, edema, rashes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025

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

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 2 residents (Resident #62) reviewed for incontinence care. When CNA-A was providing incontinent care to Resident #62 on 07/17/2025, CNA-A did not clean the resident's suprapubic area (the area of the abdomen located below the umbilical region). This failure could place residents who required incontinence care at risk for cross contamination and the development of new or worsening urinary tract infections. The findings included:Record review of Resident #62's face sheet, dated 07/18/2025, revealed the resident was a [AGE] year-old female and admitted to the facility originally on 06/06/2025, and re-admitted on [DATE] with the diagnoses of type 2 diabetes mellitus (not control blood sugar in the body), necrotizing fasciitis (serious bacteria infection that destroys tissue under the skin), chronic kidney disease (kidneys are less able to filter water and fluid out of the body), hypertension (high blood pressure), and heart failure (heart cannot pump enough oxygen-rich blood to meet the body's needs). Record review of Resident #62's admission MDS, dated [DATE], revealed the resident's BIMS score was 15 out of 15, which indicated the resident's cognitive function was intact, and the resident had indwelling urinary catheter and frequently incontinent to bowel. Resident #62 was dependent (helper does all of the effort) to sit-to-stand and chair-to-bed transfer, and for toilet transfer, not attempted due to medical condition or safety concerns. Record review of Resident #16's comprehensive care plan, dated 06/12/2025, revealed the resident has a Foley catheter (indwelling urinary catheter). For intervention - staff will clean the catheter every shift or as needed, and incontinent care every 2 hour and as needed for bowel incontinence. Observation on 07/17/2025 at 2:03 p.m. revealed CNA-A opened Resident #62's old and dirty brief and cleaned the resident's catheter, genital area by separating it with hand, and then cleaned the left and right groin area. CNA-A turned the resident to her right side without cleaning the suprapubic area, which the area was folded up with skin. CNA-A cleaned the resident's buttock area, then put a new and clean brief on the resident. Interview on 07/17/2025 at 2:17 p.m. with CNA-A stated she did not clean Resident #62's suprapubic area because she was nervous and forgot to clean the area. CNA-A said she should have opened and cleaned the area when providing peri-care to Resident #62 because the resident's suprapubic area was folded up with skin to prevent possible infection, especially fungus, and had peri-care training around two months ago. Interview on 07/17/2025 at 3:16 p.m. with DON said CNA-A should have opened and cleaned Resident #62's suprapubic area when providing peri-care to the resident because the area was folded up with skin to prevent infection. The DON stated DON had responsibility for monitoring CNA-A by checking off the CNA's skills two months ago. Record review of the facility policy, titled Perineal care, revised 02/2018, revealed The purpose of this procedures are to provide cleanliness and comfort to the resident to prevent infections and skin irritation and to observe the resident's skin condition. wash perineal area, wiping from front to back.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025

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

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 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 residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 (Resident #17) of 2 residents reviewed for enteral nutrition. When LVN-B flushed Resident #17's gastrostomy tube with 30 ml of water, LVN-B pushed water inside the barrel of the syringe with a plunger, instead of using gravity. This failure could place residents with gastrostomy tube at risk for complications, aspiration, and pneumonia. Findings included:Record review of Resident #17's face sheet, dated 07/18/2025, revealed the resident was [AGE] years old male, originally admitted on [DATE], and re-admitted to the facility on [DATE] with diagnoses of personal history of covid-19, seizures (sudden burst of electrical activity in the brain), peritonitis (redness and swelling of the lining of the belly or abdomen), hypertension (high blood pressures), and gastro-esophageal reflux disease (the stomach contents leak backward from the stomach into the esophagus). Record review of Resident #17's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 0 out of 15, which indicated the resident had severe cognitive impairment and had a feeding tube. Record review of Resident #17's comprehensive care plan, dated 05/24/2025, revealed the resident was dependent on feeding tube for nutritional needs and at risk for aspiration. For intervention - administer tube feeding as ordered, check for placement prior to feeding and flushed administration, and provide flushed as ordered to maintain hydration and patency of tube. Record review of Resident #17's physician order, dated 01/16/2025, revealed the resident had the order of Flush gastrostomy tube with 30 ml of water before and after medication and 10 ml between medication. Observation on 07/17/2025 at 10:22 a. m. LVN-B checked the placement of Resident #17's gastrostomy tube and residual, then flushed the gastrostomy tube with 30 ml of water by pushing the water inside barrel of syringe with plunger, instead of using gravity. Interview on 07/17/2025 at 10:53 a.m. with LVN-B stated he flushed Resident #17's gastrostomy tube with 30 ml of water by pushing the water inside barrel of syringe with plunger, instead of using gravity. LVN-B said he thought pushing the water for flush was fine because Resident #17 did not have residual. However, LVN-B stated he should have used gravity when flushing Resident #17's gastrostomy tube to prevent possible aspiration and the resident's abdominal discomfort. The nurse said it was mistake. Interview on 07/17/2025 at 3:16 p.m. the DON said LVN-B should have used gravity when flushing Resident #17's gastrostomy tube, instead of pushing a plunger, to prevent possible aspiration and the resident's abdominal discomfort. The DON said if gravity could not be used due to blockage of tube, nurses could push a plunger gently. The facility did not have policy regarding using gravity for tube feeding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025

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

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 - Some	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Rj Meridian Care of San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	**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 needed respiratory care, including tracheostomy care was provided such care, consistent with professional standards of practice and the comprehensive person-centered care plan for 3 of 9 Residents (Residents #1, Resident #2 and Resident #7) whose records were reviewed for oxygen use.Nursing staff failed to ensure Resident #1's oxygen concentrator was equipped with 2 filters while in use.Nursing staff failed to ensure Resident #2's oxygen concentrator was equipped with 2 filters while in use.Nursing staff failed to ensure Resident #7's oxygen concentrator was equipped with 2 filters while in use.This deficient practice could affect any respiratory on oxygen therapy and could contribute to respiratory distress, infections, pneumonia and an overall decline in their physical condition.The findings were: 1. Review of Resident #1's face sheet, dated 7/17/25, revealed he was admitted to the facility on [DATE] with diagnosis including Acute and Chronic respiratory failure respiratory failure (lungs have a hard time loading your blood with oxygen or removing carbon dioxide) with hypoxia (low levels of oxygen in your body tissues). Review of Resident 1's admission MDS assessment, dated 3/8/25, revealed his BIMS score was 11 of 15 reflective of moderate cognitive impairment, he received continuous oxygen therapy, tracheostomy care and had an invasive mechanical ventilator. Review of Resident #1's Care Plan dated 6/11/25 revealed he had ineffective breathing pattern related to inability to sustain spontaneous ventilation in which I require a mechanical ventilator. Some of the interventions included Maintain O2 setting at rate to maintain saturations above 90% and oxygen and rate per MD orders. Observation on 7/15/25 at 12:55 PM revealed Resident #1 was lying in bed asleep with a tracheostomy and ventilator in place. Resident #1 was receiving continuous oxygen at 3 liters per minute. Further observation revealed Resident #1's oxygen concentrator did not have filters, it was designed to have a filter on both sides of the concentrator. Resident #1 did not wake up to the call of his name. 2. Review of Resident #2's face sheet, dated 7/17/25, revealed he was admitted to the facility on [DATE] with diagnosis including Respiratory Failure (lungs have a hard time loading your blood with oxygen or removing carbon dioxide) with unspecified hypoxia (low levels of oxygen in your body tissues). Review of Resident #2's quarterly MDS assessment, dated 5/9/25, revealed his BIMS score was 12 of 15 reflective of moderate cognitive impairment and he received continuous oxygen therapy and used a non-invasive mechanical ventilator (BI pap, breathing machine). Review of Resident #2's CP, dated 7/5/25, revealed he received oxygen via nasal canula at times. Interventions included Administer O2 Per MD orders, Change Nasal Cannula and tubing per facility policy. Review of Resident #2's consolidated physician orders for July 2025 revealed an order for the use of the BiPap but not for the oxygen. Observation and interview on 7/15/25 at 12:45 PM revealed Resident #2 lying in bed receiving 02 via nasal cannula at 2 liters per hour. The oxygen concentrator did not have filters. The oxygen concentrator was designed to have a filter on both sides of the concentrator. Interview with Resident #2 stated he received oxygen for shortness of breath. 3. Review of Resident #7's face sheet, dated 7/17/25, revealed he was admitted to the facility on [DATE] with diagnosis including Acute and Chronic respiratory failure respiratory failure (lungs have a hard time loading your blood with oxygen or removing carbon dioxide) unspecified whether with hypoxia (low levels of oxygen in your body tissues) or Hypercapnia (elevated levels of carbon dioxide in the blood). Review of Resident 7's 5-day MDS assessment, dated 6/21/25, revealed his BIMS score had not been determined, he received continuous oxygen therapy, tracheostomy care and had an invasive mechanical ventilator. Review of Resident #7's Care Plan dated 7/14/25 revealed he had impaired cognition related to anoxic brain injury (brain damage due to loss of oxygen), history of cardiac arrest, he had ineffective breathing pattern related to inability to sustain spontaneous ventilation in which I require a mechanical ventilator. Some of the interventions included Maintain O2 setting at rate to maintain saturations above 90% and oxygen and rate per MD orders. Review of Resident #7's consolidated orders for July 2025 did not reveal an order for oxygen therapy. Observation on 7/15/25 at 12:50 PM revealed Resident #7 was lying in bed asleep with a tracheostomy and ventilator in place. Resident #7 was receiving continuous oxygen at 3 liters per minute. Further observation revealed Resident #1's oxygen concentrator did not have filters, it was designed to have a filter on both sides of the concentrator. Resident #7 did not wake up to the call of his name. Interview on 7/15/25 at 1:20 PM with LVN F revealed Resident 1#'s, Resident #2's and Resident #7s oxygen concentrator did not have filters. She stated the concentrators should have the filters to prevent debris from getting into the concentrator which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Rj Meridian Care of San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Rj Meridian Care of San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to attempt to use appropriate alternatives prior to installing a side or bed rail, assess the resident for risk of entrapment, to review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation of the bed rails for ? of 6 Residents (Resident #3, Resident #4, Resident #7 and Resident #8) whose records were reviewed for restraints. The facility failed to identify the use of bilateral use of side rails as a restraint and failed to ensure Resident #3's safety since his admission date of 05/02/2025. The facility failed to identify the use of bilateral use of side rails as a restraint and failed to ensure Resident #4's safety since his admission date of 8/10/22.The facility failed to identify the use of bilateral use of side rails as a restraint and failed to ensure Resident #7's safety since his admission date of 7/18/25. The facility failed to identify the use of bilateral use of side rails as a daily restraint and failed to ensure Resident #8's safety since his admission date of 6/7/23.This deficient practice could affect any resident using side rails and could result in serious avoidable accidents. The findings included: Review of Resident #3's face sheet, dated 7/18/25, revealed he was admitted to the facility on [DATE] with diagnoses including Dementia in other diseases classified ((loss of cognitive functioning it interferes with a person's daily life and activities), severe and Acute and chronic respiratory failure with hypoxia (low oxygen levels). Review of Resident #3's annual MDS assessment, dated 5/9/25, revealed his BIMS score was 3 indicative of severe cognitive impairment, and he had impaired range of motion on both lower extremities. Further review revealed the use of side rails was not identified as restraint use. Review of Resident #3's CP, revised 6/23/25, revealed he required total assistance by 1-2 persons with mobility. Further review revealed Resident #3 had established contractures of bilateral lower and upper extremities due to impaired mobility (upon admission). Review of Resident #3's consolidated physician orders for July 2025 revealed a side rail order MAY HAVE 1/4 SIDE RAILS UP AS NEEDED FOR ENABLER Phone Active 05/19/2025. Review of Resident #3's ADL flowsheet from 7/4/25 to 7/17/25: Self-performance: How resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture revealed he required extensive assistance on a couple of days and total assistance on most days. Review of Resident #3's assessments did not reveal a restraint assessment or consent for the use of side rail. Observation on 07/16/2025 at 10:16 AM revealed Resident #3 was lying in bed with padded 1/4 side rails on both sides of the bed. The side rails were up and locked and he also had mittens on both hands. Interview on 07/17/25 at 2:05 PM with LVN I revealed Resident #3 was totally dependent on staff for all ADL's and was not able to use the side rails for mobility especially since he wore mittens on both hands. She stated the side rails kept Resident #3 from pulling on his trachea which he would often do if he did not have mittens on. LVN I stated the side rails were used for safety because he would move throughout the bed and was a fall risk. She further stated the side rails kept him from falling out of bed. Interview on 07/17/25 at 2:10 PM with CNA H and CNA E revealed Resident #3 did not use the side rails for mobility. They stated the side rails kept him from falling out of bed because he would move all around his bed. Interview on 07/18/25 at 10:08 AM with the DON revealed Resident #3 was totally dependent on staff for all ADL's and did not use the side rails for mobility. She stated the side rails were used for safety to prevent falls so in fact they were used as restraints. The DON stated she was not aware of alternatives being used prior to installing the side rails. She stated an assessment, a consent including discussing the risks and benefits were not obtained for the use of side rails. The DON stated following these measures were important to ensure the safety of the resident and not taking these measures could result in the resident being injured. 2. Review of Resident #4's face sheet, dated 7/18/25, revealed he was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction (stroke), undifferentiated Schizophrenia (serious mental health condition that affects how people think, feel and behave. It may result in a mix of hallucinations, delusions, and disorganized thinking and behavior) and Generalized Anxiety. Review of Resident #4's annual MDS assessment, dated 5/7/25, revealed his BIMS score was 3 of 10 indicative of severe cognitive impairment and he had impaired range of motion on both upper and lower extremities. Further review revealed the use of side rails were not identified as restraint use. Review of Resident #4's CP revised on 7/5/25 revealed he required assistance with ADL's due to respiratory failure, muscle wasting and atrophy, unspecified lack of coordination, CVA, cognitive deficit. One of the interventions included Resident #3 required 2- person assistance with bed mobility. Review of Resident #4's consolidated physician orders

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	07/18/2025

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.

Based on observations, interview, and record reviews, the facility failed to provide pharmaceutical services to administer drugs and biologicals that meet the needs of each resident for 1 of 9 (Cart #1 on 400 hall) medication carts observed for expired medication in that: The facility failed to remove expired medications from medication cart #1 1 bottle of Gentle Lax and 1 bottle of Extra Strength Tylenol 500mg This failure could result in residents decreased health response or misuse of medication.Findings included:

Observation on 07/16/2025 at 10:40AM medication cart 1 of 4 for #400 hall revealed 1 bottle of Gentle Lax with an expiration date of 03/2025 and 1 bottle of Acetaminophen 500mg with expiration date of 04/2025.

Interview on 7/16/2025 at 10:45AM LVN B said he missed the expiration dates on the medications. He said it would not be safe to give because it could cause an adverse reaction to the resident or it may not be as effective to use for effective results.

Interview on 7/16/2025 at 11:10AM the DON said expired medications would not be as effective or not be able to have the therapeutic results for their use or it could cause an adverse reaction.

Record review of facility policy titled “Medication Labeling and Storage” dated February 2023 stated under “Medication Storage” 3. “If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these medications.

Findings included:

Observation on 07/16/2025 at 10:40AM medication cart 1 of 4 for #400 hall revealed 1 bottle of Gentle Lax with an expiration date of 03/2025 and 1 bottle of Acetaminophen 500mg with expiration date of 04/2025.

Interview on 7/16/2025 at 10:45AM LVN B said he missed the expiration dates on the medications. He said it would not be safe to give because it could cause an adverse reaction to the resident or it may not be as effective to use for effective results.

Interview on 7/16/2025 at 11:10AM the DON said expired medications would not be as effective or not be able to have the therapeutic results for their use or it could cause an adverse reaction.

Record review of facility policy titled “Medication Labeling and Storage” dated February 2023 stated under “Medication Storage” 3. “If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Rj Meridian Care of San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen be free from unnecessary drugs without adequate indications for its use for 3 of 5 (Resident #3, #61, and #82) residents reviewed for unnecessary medications., in that: 1. The facility failed to monitor the behaviors and side effects of Resident #3's Remeron for depression and Buspirone for anxiety. 2. The facility failed to ensure there was a correct diagnosis for the use of Zyprexa for agitation for Resident #61. 3. Resident #82 received psychoactive medications for which he did not have a documented diagnosis. This failure could lead to residents being prescribed medications without indication and place residents at risk of unnecessary side effects and a decline in overall health. The findings were: The findings included: Record review of Resident #61’s face sheet dated 7/18/2025 revealed a [AGE] year-old male was admitted on [DATE] to the facility with diagnoses that included: dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, end stage renal disease (kidney failure), and hypertension. Record review of Resident #61’s care plan dated 5/28/2025 revealed the resident was care planned for psychotropic medications with GDR interventions; falls due to lack of safety awareness with interventions side rails used as a reminder of edge of bed, staff to assist with transfers, call light in reach. He was not care planned for agitation or anxiety. Record review of Resident #61’s CMDS dated [DATE] he had a BIMS score of 14, indicative of intact cognitive status. Resident #61’s CMDS did not reveal a reason or diagnosis for anti-psychotic medication. Record review of physician orders dated 5/27/2025 revealed orders for: Zyprexa 5mg, 1 tab by mouth daily at bedtime for agitation; and Remeron 15mg 1 tab by mouth daily at bedtime for depression. Record review of Resident #61’s nursing notes for the month of May 2025 through July 2025 revealed no documentation of aggression. Record review of Resident #61's medication review dated 5/28/2025 revealed for albuterol nebulizer solution to be changed from every 2 hours prn to four times daily- every 6 hours and the changing dosage time for tamsulosin to be administered at night and potassium to be added to drug regimen because of low potassium. There was no review of Zyprexa or Remeron. Interview on 07/17/2025 11:19 AM the DON said the MDS Coordinator was on vacation. She looked into the MDS for Resident #61 and she said the resident was admitted on the medications and the doctor kept the medication until he was seen by psych. When he had the order for the eval, the NP that would have done it moved out of state, so they waited for a new person and the eval was done 7/11/2025. The DON said after he was seen by psych, they still had not taken him off the medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Rj Meridian Care of San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on phone 7/17/2025 at 2:56PM RP of Resident #61 said the resident did have a diagnosis of depression because he had been in and out of the hospital since late December 2024. She said he had never been aggressive with staff or anybody. The RP said he did have episodes of delirium when he first started dialysis because the dialysis, he received was too strong for him and when they realized it was too strong, they gave him a milder dialysis and the delirium stopped. She said she recalled a meeting she had on the phone while she was driving, they went through the medication fast, and they asked for consents for his medication, but she thought it was for his appetite, but he had never been aggressive. She said she lived in [NAME], and she did not come often, but they call her for everything that concerned him. She said she did not want him to take that because he did not have that behavior, and she would call the facility to inform them to stop it. Interview on 07/18/2025 09:13 AM Pharmacy Consultant said the medication Zyprexa was used for agitation and he was doing a report to send to the facility and he would put in a request to stop the medication. He said Zyprexa could be used in conjunction with Remeron for depression. He was informed by the surveyor that it was used for agitation and not depression. He said hospitals would discharge residents on Zyprexa and normally after 90 days if there were no behaviors, it would be discontinued. He said he would ask for GDR for Zyprexa. He was informed that the resident had no diagnosis for agitation. Interview on 7/18/2025 at 7:21PM the DON said there should be a diagnosis for administering psychotropic medication to ensure it was given for the correct reason and correct therapeutic effect. The DON said medications given without a diagnosis could cause adverse reactions or long-term issues. Record review of facility policy titled, “Pharmacy Services- Role of the Provider Pharmacy” revised 4/2019 stated in part, under subsection c. “Help the facility identify comply with its legal and regulatory requirements related to medications and medication management”, f. “Maintain a mediation profile for each patient, that includes all pertinent information, including that which is required by law and regulation”; g. “Screen new medication orders for key parameters, including appropriate indications.” Record review of the facility policy titled “Antipsychotic Medication Use,” revised 07/2022, stated in part “Antipsychotic medications shall generally be used only for the following diagnoses/conditions as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders: schizophrenia, schizoaffective disorder, schizophrenia disorder, delusional disorder, mood disorders (e.g., bipolar disorder, depression with psychotic features, and treatment refractory major depression), psychosis in the absence of dementia, and medical illness with psychotic symptoms and/or treatment-related psychosis or mania.” 1. Record review of Resident #3's face sheet, dated 07/18/2025, revealed the resident was [AGE] years old male and admitted to the facility originally on 05/02/2025, and re-admitted on [DATE] with the diagnosis of anemia (the blood does not have enough healthy red blood cells and hemoglobin),), type 2 diabetes mellitus (the body has trouble controlling blood sugar and using it for energy), anxiety disorder, depression disorder, hypertension (high blood pressure), and respiratory failure (serious condition that makes it difficult to breathe on your own). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER: Rj Meridian Care of San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's 5-days MDS, dated [DATE]/25, revealed Resident #3's BIMS score was 99 reflecting the resident was unable to interview, dependent to all activities of daily living such as bed mobility, transfer, and personal hygiene, and receiving antianxiety and antidepressant as ordered. Record review of Resident #3’s comprehensive care plan, dated 05/19/2025, revealed “the resident had at risk for side-effects due to use of antidepressant and antianxiety. For intervention – monitor for behaviors manifested and notify medical doctor if medication can be reduced and monitor for side effects.” Record review of Resident #3’s physician orders, dated 05/19/2025, revealed the resident had the orders of “Remeron oral tablet 15 mg Give 0.5 tablet enterally at bedtime for depression and Buspirone oral tablet 15 mg Give one tablet enterally two times a day for anxiety.” Record review of Resident #3's medication administration record, dated from 07/01/2025 to 07/31/2025 revealed the resident was receiving his Remeron oral tablet 15 mg Give 0.5 tablet enterally at bedtime for depression at 8:00 pm and Buspirone oral tablet 15 mg Give one tablet enterally two times a day for anxiety at 8:00 am and 8:00 pm. Further record review of the medication administration record revealed there were no order and scheduled for monitoring Resident #3’s behaviors regarding anxiety and depression and side effects regarding antianxiety and antidepressant. Interview on 07/18/2025 at 7:11 p.m. DON stated Resident #3 was still taking his Remeron for depression at bedtime and buspirone for anxiety two times a day as ordered, but there were no monitoring the resident’s behaviors and side effects regarding antianxiety and antidepressant. The facility nurses should have monitored Resident #3’s behaviors and side effects regarding antianxiety and antidepressant per the facility policy, and it was a mistake and DON's responsibility to make sure following the facility policy to prevent possible unnecessary medications. Record review of Resident #82’s face sheet, dated 07/18/2025, revealed he was admitted on [DATE] with diagnoses including Generalized Anxiety Disorder, Anemia, and Type 2 Diabetes Mellitus. Record review of Resident #82’s admission MDS, dated [DATE], revealed a BIMS score of 14 which indicated intact cognition. Record review of Resident #82’s care plan, no revision date, revealed, “I have episodes of Anxiety busPIRone HCl hydrOXYzine HCl”; “I am taking OLANZapine for episodes of Agitation”; “I am taking Divalproex Sodium for the treatment for mood”; “At risk for side effects R/T use of psychotropic medication Olanzapine dx: agitation.” (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025

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

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #82’s order summary as of 07/18/2024, revealed, “Divalproex Sodium Oral Tablet Delayed Release 500 MG (Divalproex Sodium) Give 1 tablet by mouth at bedtime for Mood GIVE one 500mg tablet with 250mg tablet to equal 750mg at bedtime”, “Divalproex Sodium Oral Tablet Delayed Release 500 MG (Divalproex Sodium) Give 1 tablet by mouth one time a day for Mood”, “hydrOXYzine HCl Oral Tablet 50 MG (Hydroxyzine HCl) Give 1 tablet by mouth every 8 hours as needed for anxiety for 14 Days”, “traZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 0.5 tablet by mouth at bedtime for Depression GIVE 1/2 50MG TAB TO = 25MG”, “Xanax Oral Tablet 0.5 MG (Alprazolam) Give 1 tablet by mouth every 8 hours as needed for ANXIETY for 14 Days”, “ZyPREXA Oral Tablet 2.5 MG (Olanzapine) Give 1 tablet by mouth at bedtime for AGITATION for 7 Days.” Further review of Resident #82’s clinical record as of 07/18/2025, revealed no documentation of the resident having diagnoses of agitation or mood. During an interview with the DON on 07/18/2025 at 7:21 p.m., the DON stated that there should be a diagnosis for administering psychotropic medications to ensure the medication was given for the correct reason. The DON stated that giving medications without a diagnosis could cause adverse reactions or long-term issues for the residents. Record review of the facility policy, Antipsychotic Medication Use, dated July 2022, revealed, Residents will not receive medications that are not clinically indicated to treat a specific condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Rj Meridian Care of San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards of food service safety for 1 of 1 kitchen, in that: The dry storage area had 2 boxes of funnel cake mix with an expiration date of 10/31/2024 hand written on the box. The dry storage area had a box of 9 juice cups with spillage and gnats in the box. The dry storage area had 2 containers of sugar with the lids not secured. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: Observation on 7/15/2025 at 11:24AM in the dry storage area, there were 2 containers with sugar and the tops of the containers were not secured to the containers. There was a box with 9 individual servings of juice cups that had spillage in the box and when the box was moved, approximately 4 gnats flew out of the box. Observed 2 boxes of funnel cake mix with no manufacturer expiration date on the box, but there was a handwritten date on the box of 10/31/2024. Interview on 7/15/2025 at 11:24AM the DM said, When in doubt, throw it out and mumbled an explicit statement under his breath, Fuck! Shit!,when he saw the unsecured containers of sugar. Ther DM said it was important to make sure foods were not expired and to make sure foods were properly stored because contamination or cross contamination could happen and cause food borne illness for the residents. Interview on 7/17/2025 at 1:45PM the RD said it was important to keep food in airtight containers to protect the integrity of the food and to protect it from contamination and cross contamination. She said bugs or debris could contaminate containers that were not sealed properly. The RD said expired food should not be served because it could cause food borne illness to the residents that received food from the kitchen. The RD said an in-service would be done immediately with the kitchen staff. Interview on 7/18/2025 at 3:30PM The DM said it was important to store food properly to prevent food borne illness to the residents. He said food that was expired should not be stored to use because it could cause the residents to become ill and cause food borne illness. Record review of facility policy titled Food Receiving and Storage dated November 2022 stated: Foods shall be received and stored in a manner that complies with safe food handling practices. Under section titled: Dry Food Storage stated: 3. Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready to use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Rj Meridian Care of San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE 7181 Crestway Dr San Antonio, TX 78239	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 1 (Resident #7) out of 18 residents reviewed for medical records. Resident #7's psychiatric doctor added the resident's general anxiety as one of the resident's diagnosis and prescribed diazepam 2 mg three times a day for anxiety, but the facility did not add the new diagnosis to the resident's medical record. This failure placed residents at risk for missed treatment and medications which could result in decline in heal and well-being. Findings included: Record review of Resident #7's face sheet, dated 07/18/2025, revealed the resident was [AGE] years old female and admitted to the facility on [DATE] with diagnosis of abnormal findings in urine, type 2 diabetes mellitus (not control blood sugars in the body), hypertension (high blood pressures), hyperlipidemia (high fat in the body), cystitis (urinary bladder infection), and gastro-esophageal reflux disease (the stomach contents leak backward from the stomach into the esophagus). Further record review of Resident #7's face sheet did not have diagnosis of general anxiety. Record review of Resident #7's 5-days MDS, dated [DATE], revealed the resident's BIMS was 0 out of 15, which indicated the resident had severe cognitive impairment and receiving antianxiety as ordered. Record review of Resident #7's physician order, dated 05/23/2025, revealed the resident had the order of Diazepam oral tablet 2 mg Give one tablet enterally three times a day for anxiety. Record review of Resident #7's medication administration record from 07/01/2025 to 07/31/2025 revealed the resident's Diazepam oral tablet 2 mg Give one tablet enterally three times a day for anxiety was scheduled 7:00 am, 1:00 pm, and 7:00 pm. Record review of Resident #7's psychiatric physician note, dated 05/30/2025, revealed the resident's psychiatric doctor added the resident's general anxiety as one of the resident's diagnoses and currently used diazepam 2 mg three times a day for anxiety. Record review of Resident #7's medical diagnosis list of the resident's electronic medical record revealed there was no diagnoses of general anxiety. Interview on 07/18/2025 at 7:59 p.m. DON stated Resident #7 was receiving Diazepam 2 mg three times a day enterally for the resident's anxiety, and the resident's psychiatric doctor added the diagnoses of general anxiety, but the facility did not update it to the resident's medical record. The resident's medical record was not accurate. Updating medical record was one of MDS nurse's responsibilities, but the facility did not have MDS nurse, and it might cause inaccurate medical record. Inaccurate medical record might cause improper care to the resident. Record review of the facility policy, titled Electronic Medical Records, revised 03/2014, revealed Electronic medical records may be used on lieu of paper records when approved by the Administrator.

Printed: 11/21/2025
Form Approved OMB
No. 0938-0391

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	07/18/2025

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

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 Based on observations, interviews, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 2 (Resident #3, Resident #70) of 18 residents reviewed for infection control practices. 1. CNA-C changed her gloves without sanitizing or washing her hands during emptying Resident #3's colostomy bag on 07/17/2025. 2. RT-J changed her gloves without washing her hands or using hand sanitizer while providing tracheostomy care for Resident #70. 3. LVN-I touched curtains, bed rails with gloves before she administered medication through peg tube for Resident #3. These deficient practices could place residents at risk for cross contamination and infections.Facility

Record review of Resident #70’s Care Plan dated 7/4/2025 revealed she required EBP; she was at risk of falls and the family did not want the bed lower because they want her to be in view of the camera; she used oxygen via tracheostomy.

Record review of Resident #70’s QMDS dated [DATE] revealed she had a BIMS score of 99 indicative of severe cognitive deficit and unable to interview; peg tube; total dependent on staff for all assistance; oxygen therapy with tracheostomy, and suctioning.

Observation on 07/17/2025 at 08:10 AM of medication pass LVN-I donned gloves and then the gown for EBP for Resident #3. With the clean gloves, closed the privacy curtain, touched the bed control and began administering the resident's medications through the peg tube without changing her gloves.

Interview on 7/17/2025 at 8:35AM the DON said, “Oh my God. LVN-I should have changed her gloves after touching everything in the room or not wear gloves and wash her hands again before putting clean gloves on and rendering care to the resident”. The DON said RT-J should have either washed her hands or used hand sanitizer before she put on new gloves. The DON said not following infection control policy could cause bacteria and infection to be passed to the residents.

Record review of policy titled “Hand Hygiene” not dated stated “Gloves are for protection, not prevention of pathogen transfer. Gloves prevent the transfer of pathogens to your hands, but they can still become contaminated. If gloves become contaminated, they should be removed and replaced”; “If your gloves touch anything outside the designated G-tube care field (e.g. bed rails, clothing, surfaces), remove and discard them immediately, wash your hands, and put on a fresh pair before continuing”; And “Avoid touching clean items or surfaces with potentially contaminated gloves’; “ if gloves are contaminated, change them immediately to prevent the spread of infection”.

Record review of policy from CDC titled “Tracheostomy Care” dated 7/2025 stated 4. ‘When cleaning tracheostomy tube site, use aseptic technique and hand hygiene”.

No Notes

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Rj Meridian Care of San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE 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	1. Record review of Resident #3's face sheet, dated 07/18/2025, revealed the resident was [AGE] years old male and admitted to the facility originally on 05/02/2025, and re-admitted on [DATE] with the diagnosis of anemia (the blood does not have enough healthy red blood cells and hemoglobin),), type 2 diabetes mellitus (the body has trouble controlling blood sugar and using it for energy), anxiety disorder, depression disorder, hypertension (high blood pressure), and respiratory failure (serious condition that makes it difficult to breathe on your own). Record review of Resident #3's 5-days MDS, dated [DATE], revealed Resident #3's BIMS score was 99 reflecting the resident was unable to interview, the resident had colostomy, and dependent to all activities of daily living such as bed mobility, transfer, and personal hygiene, and receiving antianxiety and antidepressant as ordered. Record review of Resident #3’s comprehensive care plan, dated 05/19/2025, revealed “the resident had colostomy. For intervention – staff to provide colostomy care every shift and as needed. ” Observation on 07/17/2025 at 2:45 p.m. revealed CNA-C opened Resident #3’s colostomy bag and emptied feces to a plastic bag, then changed gloves without sanitizing or washing CNA-C’s hands. CNA-C cleaned the bag and closed the pouch clamp, then changed gloves without sanitizing or washing CNA-C’s hands. CNA-C removed all equipment and took off her gloves and sanitized her hands before leaving the resident’s room. Interview on 07/17/2025 at 2:55 p.m. CNA-C stated she changed gloves without sanitizing or washing hands after emptying Resident #3’s feces and cleaning the colostomy bag. Further interview with CNA-C said she received hand hygiene training and she said she should have sanitized or washed her hands between changing her gloves to prevent possible infection, especially contacting to body fluid. Interview on 07/18/2025 at 11:40 a.m. DON said CNA-C should have sanitized or washed her hands between changing her gloves to prevent possible infection, especially contacting to body fluid per the facility policy. It was infection control issue.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Rj Meridian Care of San Antonio		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 (Resident #16) of 18 residents reviewed for environmental concerns. Resident #16's oxygen cylinder was stored in the resident room, but per the facility policy indicated Do not oxygen cylinder in any resident room or living area. This failure could place residents at risk of a diminished quality of life and respiratory status due to exposure to an environment that is unpleasant, unsanitary, and unsafe. The findings included:Record review of Resident #16's face sheet, dated 07/18/2025, revealed the resident [AGE] years old female, originally admitted to the facility on [DATE], and re-admitted on [DATE] with diagnosis of dysphagia (difficulty of swallowing), chronic pain, encephalopathy (brain damage), hyponatremia (level of sodium in the blood is too low), and personal history of covid-19. Record review of Resident #16's quarterly MDS, dated [DATE], revealed the resident's BIMS was 9 out of 15 indicated the resident had moderate cognitive impairment, required dependent on assist (Helper does ALL of the effort) to chair to bed transfer, and for toilet transfer, not attempted due to medical condition or safety concerns. Record review of Resident #16's comprehensive care plan, dated 06/23/2025, revealed the resident nebulizer breathing treatment ordered due to respiratory failure. For intervention - observe for sign and symptoms of adverse reactions: increased dyspnea (difficulty of breathing). Record review of Resident #16's physician order, dated 07/15/2025, revealed oxygen at 2 to 4 liters per minute via nasal canula to maintain oxygen saturation greater than 90 % and record saturation every shift. Observation on 07/15/2025 at 1:34 p.m. revealed there was one oxygen cylinder found in Resident #16's room, and the cylinder had full oxygen. Interview on 07/15/2025 at 1:34 p.m. LVN-D stated there was one oxygen cylinder found in Resident #16's room, and it should have been stored in the oxygen storage room, instead of resident's room for safety. LVN-D said she did not know how long it was stored in the room and what reason the oxygen cylinder was in Resident #16's room because the resident never use it. Interview on 07/18/2025 at 11:10 a.m. the DON said all oxygen cylinder should have been stored in the oxygen storage room for safety, instead of resident's room. Record review of facility policy, titled Fire Safety and Prevention, revised 05/2017, revealed Oxygen safety: . F. store oxygen cylinders in racks with chains, sturdy portable carts, or approved stands. Never leave oxygen cylinder free-standing. Do not oxygen cylinders in any resident room or living area.