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	05/31/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42031 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Resident #27), reviewed for care plans. Resident #27 had an order to remove his mitten restraints every 2 hours for ten minutes but the care plan documented to visually observe the mitten restraints every 2 hours. This failure could place residents at risk of not receiving necessary services to meet their needs, pain, blood flow complications, and contractions. The findings were: Record review of Resident #27's face sheet dated 5/30/24 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with readmission on 2/16/24. The diagnoses included other speech and language deficits following cerebral infarction (speech and language deficits occur as a result of disrupted blood flow to the brain), Tracheostomy status (an opening into the trachea (windpipe) from outside the neck for breathing), Anxiety Disorder (excessive, ongoing anxiety and worry that interferes with daily activities), and other schizophrenia (symptoms such as delusions, hallucinations, disorganized thinking and speech and bizarre and inappropriate motor behavior). Record review of Resident #27's quarterly MDS assessment dated [DATE] revealed the resident had unclear speech, was sometimes understood and could make simple concrete requests only, was sometimes able to understand but was limited to simple direct communication only. The resident had no BIMS score and was moderately cognitively impaired per assessment. His limb restraints were used in and out of bed daily. Record review of Resident #27's care plan, dated 5/30/24 revealed a focus for hand mitten restraints to prevent pulling of medical tubing with a goal the resident will not pull out his tubing and a goal with a target date of 8/22/24 that there would be no injury related to restraints, and tubing would remain in place. Interventions included to apply hand mittens to both hands and to visually check them every 2 hours. (There was no intervention to release the restraints for skin check or exercise) (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #27's physician orders revealed an order dated 5/14/24 for soft mitten restraints may be placed to both hands to prevent pulling of trach and vent equipment and to release every 2 hours X (for in this instance) 10 minutes for skin check and exercise. (Soft mitten restraints encase the hands and fingers and secure at the wrist, the palm side of the mitten restraint is heavily padded and prevents the person from making a fist or otherwise using their fingers to remove medically necessary equipment) Record review of Resident #27's EMAR for May 2024 revealed the nursing staff were signing off the release of the restraints was completed as ordered every 2 hours. In an observation on 5/28/24 at 10:50 am, Resident #27 was in a low bed with mitten restraints on both of his hands, trach oxygen was at 4 liters per minute. The resident was moving his hands and would lay his head on his hands, that were inside the padded mitten restraints. The resident was unable to respond to questions. In an observation and interview on 05/31/24 at 12:15 p.m., LVN A was observed reapplying the mitten restraints for the resident and stated she did them one at a time because she has to hold his hand and talks to him calmly or he will pull out the trach so she talks to him about his family while checking the skin on his hand and finger exercises. LVN A further stated she was unsure why the care plan had only to visually check them because the order was to remove them every 2 hours to check his skin and exercise his hands and fingers and that was what the nurses did. In an interview on 5/31/24 at 11:00am, the DON confirmed the mitten restraints were being removed every 2 hours as ordered and she was unsure why the care plan had to only visually observe them. Review of the facility's policy on comprehensive assessments revealed the comprehensive assessments are conducted to assist in developing person-centered care plans. And .8. A significant error is an error in an assessment where: a. The resident's overall clinical status is not accurately represented on the erroneous assessment and or results in an inappropriate plan of care

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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. 46677 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for 1 of 1 kitchen observed for food service. The facility failed to ensure that items stored in the reach in refrigerator were labeled after opened. This failure affect the residents who received meals from the kitchen and place them at risk for foodborne illness. Findings included: Observation of the facility's reach in refrigerator on 05/23/2024 at 9:03 AM revealed two open (1) gallon jugs of ranch dressing unlabeled. Interview with the Dietary Manager (DM) on 05/23/2024 at 9:05 AM revealed all food was to be labeled after being open and stored either in the refrigerator, freezer, or in the dry storage. The DM stated staff were trained by her, when they started, that all food was to be labeled with the date opened and date to be used by after it was opened. The DM stated that all staff were responsible to label open food being stored. Record review of the facility's policy named Food Receiving and Storage dated 2022 revealed All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2017, U.S. Department of H&HS, revealed, 3-305.1, Food Storage, (A) Food shall be protected from contamination by storing the food: (1) in a clean, dry location; (2) Where it is not exposited to splash, dust, or other contamination.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42031 Based on interview and record review, the facility failed to, in accordance with accepted professional standards and practices, maintain medical records on each resident that were accurately documented for 5 of 30 residents (Residents #14, #20, #27, #32, and #236) , reviewed for administration. The facility failed to ensure blood pressures for Residents #14, #20, #27, #32, and #236 were documented as the same on different shifts on the same days when administering blood pressure medications. This failure could result in decreased continuity of care, medication errors, illness, and inaccurate assessments. The findings were: Record review of Resident #14's face sheet dated 5/31/24 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with readmission on 5/16/24. The diagnoses included essential primary hypertension (abnormally high blood pressure that's not the result of a medical condition). Record review of Resident #14's quarterly MDS assessment dated [DATE] revealed the resident was understood and able to understand and had a BIMS score of 15 indicating the resident was cognitively intact and the resident had a diagnosis of hypertension. Record review of Resident #14's care plan undated revealed a focus for hypertension medication with a goal with a target date of 8/1/24 that the resident's blood pressure will be stable, interventions included to monitor blood pressure as ordered and notify MD if results are high or low. Record review of Resident #14's physician orders revealed an order with a start date of 5/16/24 for metoprolol tartrate 25mg (medication used to treat hypertension) twice daily for hypertension and to hold the medication for a SBP<110 or pulse <60. Record review of Resident #14's EMAR for May 2024 revealed Metoprolol 25mg was administered by CMA B on 5/18/24 at 8:00 a.m. and the 8:00 p.m. dose with a B/P of 132/81 and on 5/26/24 at 8:00 a.m. and 8:00 p.m. with a B/P of 128/78. Record review of Resident #20's face sheet dated 5/31/24 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with readmission on 1/1/24. The diagnoses included essential primary hypertension (abnormally high blood pressure that is not the result of a medical condition). Record review of Resident #20's quarterly MDS dated [DATE] revealed the resident was usually understood and usually understands, had a BIMS score of 10/15 indicating the resident was moderately cognitively impaired and had hypertension. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #20's care plan undated revealed a focus for receiving medications to treat hypertension with a goal that his blood pressure will be stable with a target date of 6/11/24. Interventions included to monitor blood pressure as ordered and notify MD if results were high or low. Record review of Resident #20's physician orders revealed an order for metoprolol tartrate (medication used to treat hypertension) 25mg twice daily and to hold for SBP<110 or pulse<60. Record review of Resident #20's EMAR for May 2024 revealed Metoprolol was administered on 5/3/24 by CMA B at the 9:00 a.m. and 9:00 p.m. doses with the same B/P of 149/72 and P-64. Record review of Resident #27's face sheet dated 5/30/24 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with readmission on 2/16/24. The diagnoses included essential primary hypertension (abnormally high blood pressure that is not the result of a medical condition), and Atrial Fibrillation (abnormal heart rhythm). Record review of Resident #27's quarterly MDS assessment dated [DATE] revealed the resident had unclear speech, was sometimes understood and could make simple concrete requests only, was sometimes able to understand but was limited to simple direct communication only. The resident had no BIMS score and was moderately cognitively impaired. Record review of Resident #27's care plan undated but accessed on 5/30/24 revealed a focus for a potential for an irregular heart rate with a goal that the heart rate will not be less than 55 or greater than 100 with a target date of 8/22/24. Interventions included monitoring the resident's vital signs and reporting abnormal values to the MD. Record review of Resident #27's physician orders revealed an order dated 2/17/24 for metoprolol tartrate 25mg twice daily and to hold for SBP<110 or pulse<60. Record review of Resident #27's EMAR for May 2024 revealed LVN C documented administering metoprolol on 5/12/24 at 8:00 a.m. and 8:00 p.m. with B/P of 123/78. On 5/18/24 LVN C documented both the 8:00 a.m. and 8:00 p.m. with B/P of 118/67. On 5/19/24 LVN C documented both the 8:00 a.m. and 8:00 pm. doses with the B/P of 120/70. On 5/25/24 LVN C documented both the 8:00 a.m. and 8:00 pm. doses with the B/P of 142/86. And on 5/26/24 LVN C documented both the 8:00 a.m. and 8:00 pm. doses with the B/P of 122/73, P-58. Record review of Resident #32's face sheet dated 5/31/24 revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with readmission on 1/16/24. The diagnoses included essential primary hypertension. Record review of Resident #32's admission MDS revealed the BIMS score was blank and the resident was moderately cognitively impaired per staff assessment. The resident was rarely or never understood or understands and had hypertension. Record review of Resident #32's care plan undated revealed a focus for receiving medications to treat hypertension with a goal that her blood pressure would be stable with a target date of 7/24/24. Interventions included to monitor blood pressure as ordered and notify the MD of high or low results. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #32's physician orders revealed an order dated 2/9/24 for metoprolol tartrate 50mg four times daily and to hold for SBP<110 or pulse<60. Record review of Resident #32's EMAR for May 2024 revealed metoprolol was documented as administered by LVN C on 5/4/24 at the 9:00 a.m. and 1:00 p.m. doses with a B/P of 126/78 P-92 and at the 5:00 p.m. and 9:00 p.m. doses with a B/P of 132/71. On 5/11/24 at the 9:00 a.m. and 1:00 p.m. doses with a B/P of 142/84 P-83, and at the 5:00 p.m. and 9:00 p.m. doses with a B/P of 136/80 P-88. On 5/12/24 at the 9:00 a.m. and 1:00 p.m. doses with a B/P of 136/80 P-74 and at the 5:00 p.m. and 9:00 p.m. doses with a B/P of 129/77. On 5/18/24 at the 5:00 p.m. and 9:00 p.m. doses with a B/P of 127/74 P-86. On 5/19/24 at the 9:00 a.m. and 1:00 p.m. doses with a B/P of 126/76 P-69 and at the 5:00 p.m. and 9:00 p.m. doses with a B/P of 134/74. On 5/25/24 at the 9:00 a.m. and 1:00 p.m. and at the 5:00 p.m. and 9:00 p.m. doses with a B/P of 130/70 P-78 (all doses that day). On 5/26/24 at the 9:00 a.m. and 1:00 p.m. doses with a B/P of 136/82 P-81 and at the 5:00 p.m. and 9:00 p.m. doses with a B/P of 136/82 P-85. Record review of Resident #236's face sheet dated 5/31/24 revealed the resident was a [AGE] year-old male admitted to the facility on [DATE]. The diagnoses included essential primary hypertension, and atrial fibrillation. Record review of Resident #236's admission MDS dated [DATE] revealed the resident had a BIMS of 15 indicating the resident was cognitively intact and the resident took medication for hypertension. Record review of Resident #236's care plan undated revealed a focus for receiving medications to treat hypertension with a goal for his blood pressure to be stable. Interventions included monitoring the blood pressure as ordered and reporting high or low readings to the MD. Record review of Resident #236's physician orders revealed an ordered dated 5/20/24 for metoprolol tartrate 25mg twice daily and to hold for SBP<110 or pulse<60. Record review of Resident #236's EMAR for May 2024 revealed metoprolol was documented as given by LVN D on 5/25/24 and 5/26/24 at the 7:00 p.m. doses with a B/P of 132/78 P-95. Record review of physician progress notes dated 5/31/24 revealed on 5/31/24 the MD was at the facility and documented he was aware of repeat vital signs and had reviewed the medical records for the residents affected and documented there was no ill effects or hospitalization s attributed to the vital signs documented. During an observation and interview on 5/30/24 at 3:59 p.m. of medication pass with CMA B revealed the CMA was taking blood pressures prior to administering medications. CMA B stated he always took the blood pressures prior to administering blood pressure medications. In an interview on 5/31/24 at 11:55am, LVN C stated she took her own vital signs and writes them down on a piece of paper she carries with her in case she is not able to put them in the computer right away. LVN C stated she must have hit the use last documented button but it would not happen again. LVN C stated she still has her papers that she documents the vital signs on and was giving it to the DON. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 5/31/24 at 12:03 p.m. LVN D stated he took his own vital signs and has his own machine that has memory on it and writes his vital signs on a piece of paper and he still has the paper and will get it to the DON. LVN D stated he preferred to take his own vital signs rather than trust someone else taking them. He further stated he would never give a blood pressure medication without checking the blood pressure and pulse first. Review of nursing staff papers provided to the DON by LVN C, LVN D, and CMA B on 5/31/24 revealed blood pressures were different than the ones documented and were within normal limits. There were no repeat blood pressures documented. During an interview on 5/31/24 at 12:30pm, the DON stated they investigated the repeat vital signs and have removed the use last documented button in PCC and have started medication error reports for all residents involved. The DON further stated the MD had been at the facility that morning and reviewed all the medical records of the residents affected and no ill effects or hospitalization s were attributed to the repeated vital signs. During an interview on 5/31/24 at 8:40 a.m., the Administrator said she and the DON started in-serviced the nurses that had recorded the same blood pressures repeatedly. Administrator stated that by not recording accurate blood pressures, the EMAR did not reflect the effectiveness of the medications. Administrator went on to state that the facility disabled the use last vitals feature PCC. Review of the DON documentation that the residents were interviewed on 5/31/24 and all stated their blood pressures were taken by the staff prior to receiving their blood pressure medications every time. Review of the facility's policy on administering medications revised April 2019, indicated the medications were administered in accordance with prescriber orders, including any required time frame.