STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455444	A. BUILDING _____ B. WING _____	**08/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MESA VISTA INN HEALTH CENTER	**5756 N KNOLL DR SAN ANTONIO, TX 78240**

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

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F 0576 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure residents have reasonable access to and privacy in their use of communication methods.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that the resident had the right to have reasonable access to the use of a telephone and a place in the facility where calls could be made without being overheard for 1 of 1 Residents (#1) whose records were reviewed. Resident #1 was not able to make a private phone call without staff present. This deficient practice could affect all residents and resulted in feelings of anxiety and helplessness. The findings were: Review of Resident #1's face sheet, dated 8/27/20, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's Care Plan dated 7/22/20 and last updated 7/29/20 revealed the resident was at risk for psychosocial well-being concern related to medically imposed restrictions of COVID-19 precautions with interventions which included: Provide alternative methods of communications with family/visitors. Record review of Resident #1's 5-day admission MDS dated [DATE] revealed a BIM's score of 6 which indicated a severe cognitive impairment with disorganized thinking that changes in severity and comes and goes. Interview on 8/25/20 at 4:20 PM with Resident #1, the resident requested assistance with making a phone call to a family member and indicated she did not have a place to make a phone call. When asked how she normally made a phone call, Resident #1 stated that sometimes she could make a call from the nurse's station, but indicated she was afraid to ask the staff for assistance because she felt like the staff did not like her and would tell her no. Interview on 8/25/20 at 4:25 PM LVN A stated there was no private place for residence to make phone calls and the facility did not have a cordless phone for the residence to use. LVN A stated residents could make limited phone calls at the nurse's station but a nurse had to assist with the call. Observation on 8/25/20 at 4:27 PM revealed Resident #1 approached the nurse's station with a piece of paper with her family members number written on the paper. LVN B asked Resident #1 who she wanted to call and dialed the number for the resident. LVN B stood shoulder to shoulder with the resident during the phone call. This surveyor asked LVN B twice if the resident could have privacy while she was speaking to her family member. LVN B maintained close contact with the resident including leaning towards the resident when Resident #1 turned her head away from LVN B as the resident whispered part of her conversation to her family member. Another staff member, LVN C stood behind the resident during the phone call. After the resident completed her call, LVN B asked Resident #1 if everything was okay? When Resident #1 did not respond to the question, LVN B again asked the Resident #1 if everything was okay. Interview on 8/25/20 at 4:27 PM LVN B confirmed residents could not make private phone calls. LVN B stated, we (staff) are required to monitor the residents during calls. LVN B further indicated Resident #1 had dementia and monitoring was necessary to ensure residents were not calling 911. Interview on 8/25/20 at 6:45 PM with a family member of Resident #1 revealed Resident #1 was used to speaking to the family member several times a day and the resident was able to have meaningful conversations with family. The family member indicated they were pleasantly surprised when the resident had called today because most of the time the family member had to call the facility to speak with the resident. The family member stated it was difficult to get a call thru to Resident #1 because even when they called they had to wait on hold of 15 plus minutes at a time or the phone would just ring at the nurse's station and no one would answer. Interview on 8/27/20 at 9:52 AM ADON D stated staff could offer residents privacy during phone calls except if they had a history of [REDACTED]. The ADON confirmed Resident #1 had never attempted to call 911. ADON D stated residents can request to have a private conversation and indicated that most of the residents do not make that request. The ADON stated there was a corded phone that was kept in her office that could be taken into a resident room for a private phone call. Interview on 8/27/20 at 10:44 AM with the DON confirmed staff were expected to allow residents to use the phone in privacy. Interview on 8/27/20 at 11:01 AM with the Administrator confirmed the facility had a corded traveling phone that could be placed in a resident room for a private phone call. The Administrator stated LVN B would need to be retrained. Review of a facility policy, titled Resident Rights undated, revealed: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy. Information and communication: 5. The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard.
F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to immediately consult with the physician when there was a significant change in the physical, mental, or psychosocial status for 1 of 5 residents (Resident #3) reviewed for notification of changes, in that; Resident #1's physician was not consulted and the RP was not notified when the resident developed significant discoloration, pus formation and pain to the residents 3rd toe on the right foot. This failure could affect residents at the facility and place them at risk for a delay in care and treatment necessary to prevent a serious decline in health, hospitalization , or death. The findings were: Record review of Resident #1's face sheet, dated 8/27/20 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's Care Plan dated 7/22/20 and last revised 7/29/20 revealed the resident had a potential for pressure ulcer development with intervention which included: Inform the resident/family/caregivers of any new area of skin breakdown. Notify nurse immediately of any new areas of skin breakdown: open area, redness, blisters, bruises, discoloration noted during bath or daily care. Further review of Resident #1's Care Plan revealed the resident had diabetes mellitus with interventions which included: check all of body for breaks in skin and treat promptly as ordered by doctor. Monitor/document/report to MD PRN for signs and symptoms of infection to any open areas: redness, pain, heat, swelling or pus formation. Notify the charge nurse for open areas, sores, pressure areas, blisters, [MEDICAL CONDITION] or redness to the feet. Refer to podiatrist/foot care nurse to monitor/document foot care needs . Review of Resident #1's 5-day admission MDS dated [DATE] revealed a BIM's score of 6 which indicated a severe cognitive impairment with disorganized thinking that changes in severity and comes and goes. Observation on 8/25/20 at 4:20 PM of Resident #1 revealed the resident had significant discoloration to the 3rd toe on the resident's right foot. Further observation of the toe revealed the toe was black and purple from the tip of the toe covering 3/4 of the length of the toe. Where the black and purple discoloration stopped, the toe had redness extending the entire length of the toe. There was a dime sized wheel filled with a white substance consistent with pus just below the toenail on the top and right side of the toe. Interview on 8/25/20 at 4:20 PM with Resident #1 revealed the resident was having some pain in the toe while walking. Resident #1 stated on 8/24/20 she had informed ADON D of the condition of her

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) toe. Resident #1 stated they won't do anything about it. I think it's because they don't like me. Interview on 8/25/20 at 6:45 PM with Resident #1's RP revealed the resident had informed him in a phone call on 8/24/20 that her toe was hurting. The RP indicated he spoke on the phone with ADON D on 8/24/20 about the toe in which he was assured by the ADON that a physician had assessed the toe and the toe was being treated with skin prep. Interview on 8/25/20 at 9:30 AM with LVN B revealed she was not aware of the condition of Resident #1's toe prior to surveyor intervention. LVN B stated, the toe looks infected and confirmed the resident physician should be notified. Interview on 8/27/20 at 9:52 AM ADON D confirmed she was aware of Resident #1's injury to her toe. The ADON D stated she notified the Treatment Nurse, LVN E, of the toe injury and the toe had been assessed. ADON D confirmed she did not notify the residents physician of the condition to Resident #1's toe and further confirmed she had forgotten about the toe because she got involved with COVID preparations. Interview on 8/27/20 at 10:26 AM with the Treatment Nurse, LVN E, revealed he was not aware of an injury or wound to Resident #1's toe. Further interview revealed he did not look at the toe and did not notify any physician about Resident #1's toe because he was not aware of the change in condition. Interview on 8/27/20 at 10:44 AM, the DON was shown a picture of Resident #1's 3rd toe. The DON indicated she would expect any staff member who was aware of this type of injury or wound to notify the resident's nurse and for the nurse to notify the wound care nurse (Treatment Nurse), the resident's physician and the residents RP of a change in skin condition. The DON indicated the nurse should document in the residents record the wound/injury and continue to monitor. Review of a facility policy, titled Notifying the Physician of Change in Status dated March 11, 2013 revealed: The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgment deem it necessary for immediate medical attention. 1. The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide residents who were unable to carry out activities of daily living the necessary services to maintain good personal hygiene to dependent residents for 1 of 1 residents (Resident #1) reviewed for ADL care: Nursing staff did not shower Resident #1 for 9 days. This deficient practice could affect residents who required assistance with showers in the facility and it could contribute to poor hygiene and skin breakdown. The findings were: Review of Resident #1's face sheet, dated 8/27/20 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's Care Plan dated 7/22/20 and last updated 7/28/20 revealed the resident had an ADL (activities of daily living) performance deficit related to impaired strength, balance and cognition with interventions which included: bed mobility and walking but did not include any interventions for bathing or showering, personal care or toileting. Further review of the care plan revealed the care plan did not address any refusals of care. Review of Resident #1's 5-day admission MDS dated [DATE] revealed a BIM's score of 6 which indicated a severe cognitive impairment with disorganized thinking that changes in severity and comes and goes. Further review of the MDS revealed the resident required a one person staff assistance with toileting and personal hygiene and was totally dependent on one staff person for assistance with bathing. Review of shower/bath skin assessments from 8/12/20 thru 8/25/20 revealed there were no shower sheets that could be located for Resident #1. Review of PCC (Point Click Care) documentation for showers/baths revealed the last documented shower/bath was 8/18/20. Interview on 8/25/20 at 4:20 PM with Resident #1 revealed the resident didn't remember when she last had a shower/bath. Interview on 8/27/20 at 9:10 AM with LVN B confirmed Resident #1 did not have any documented showers/baths since 8/18/20. Interview on 8/27/20 at 9:52 AM ADON D confirmed that because of COVID preparations at the facility, the staff assignments for showers/baths had changed frequently. ADON D further stated she didn't know who was assigned to assist Resident #1 with showers during the past two weeks. The ADON confirmed showers should be documented in PCC but stated, sometimes they are not. Interview on 8/27/20 at 10:44 AM the DON stated all showers should be documented in PCC. Interview 8/27/20 at 10:12 AM, CNA F confirmed she had been assigned to showers/baths for Resident #1 for the week of 8/24/20-8/27/20. Further interview revealed she had not assisted Resident #1 with showering/bathing during this time because the staff was moving residents around for COVID preparations. Review of a staff policy titled, Bath, Tub/Shower dated 2003 revealed: Bathing by tub bath or shower is done to remove soil, dead [MEDICATION NAME] cells, microorganisms from the skin and body odor to promote comfort, cleanliness, circulation and relaxation. Goals: The resident will maintain intact skin integrity
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 residents received proper treatment and care to maintain good foot health for 1 (Resident #1) of 5 residents reviewed for foot care. The facility failed to thoroughly examine Resident #1's feet for injury and wounds based on Resident #1's Care Plan for a potential for an increased risk for infection to the feet due to diabetes mellitus. This failure could affect residents with diabetes mellitus by placing them at risk for poor foot health, infection, and a decline in health. Findings included: Review of Resident #1's face sheet, dated 8/27/20 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's Care Plan dated 7/22/20 and last revised 7/29/20 revealed the resident had a potential for pressure ulcer development with intervention which included: Inform the resident/family/caregivers of any new area of skin breakdown. Notify nurse immediately of any new areas of skin breakdown: open area, redness, blisters, bruises, discoloration noted during bath or daily care. Further review of Resident #1's care plan revealed the resident had diabetes mellitus with interventions which included: check all of body for breaks in skin and treat promptly as ordered by doctor. Monitor/document/report to MD PRN for signs and symptoms of infection to any open areas: redness, pain, heat, swelling or pus formation. Notify the charge nurse for open areas, sores, pressure areas, blisters, [MEDICAL CONDITION] or redness to the feet. Refer to podiatrist/foot care nurse to monitor/document foot care needs . Review of Resident #1's 5-day admission MDS dated [DATE] revealed a BIM's score of 6 which indicated a severe cognitive impairment with disorganized thinking that changes in severity and comes and goes. Further review of the MDS revealed the resident required a one-person staff assistance with toileting and personal hygiene and was totally dependent on one staff person for assistance with bathing. Further review of the MDS revealed the resident did not have any pressure wounds or ulcers and no evidence of ulcers, wounds or skin problems. Review of Resident #1's weekly skin assessment dated [DATE] revealed the resident had no documented sores, wounds or injuries to her skin. Review of shower/bath skin assessments from 8/12/20 thru 8/25/20 revealed there were no shower sheets that could be located for Resident #1. Review of PCC (Point Click Care) documentation for showers/baths revealed the last documented shower/bath was 8/18/20. Observation on 8/25/20 at 4:20 PM of Resident #1 revealed the resident had significant discoloration to the 3rd toe on the resident's right foot. Further observation of the toe revealed the toe was black and purple from the tip of the toe covering 3/4 of the length of the toe. Where the black and purple discoloration stopped the toe had redness extending the entire length of the toe. There was a dime sized wheel filled with a white substance consistent with pus just below the toenail on the top and right side of the toe. Interview on 8/25/20 at 4:20 PM with Resident #1 revealed the resident was having some pain with walking in the toe. Resident #1 stated on 8/24/20 she had informed ADON D of the condition of her toe. Resident #1 stated they won't do anything about it. I think it's because they don't like me. Interview on 8/27/20 at 9:52 AM ADON D confirmed she was aware of Resident #1's injury to her toe. The ADON D stated she notified the Treatment Nurse, LVN E of the toe injury and the toe had been assessed. ADON D confirmed she did not notify the residents physician of the condition to Resident #1's toe and further confirmed she had forgotten about the toe because she got involved with COVID preparations. Further interview with the ADON revealed because of COVID preparations at the facility that the staff assignment for showers/baths had changed frequently. The ADON indicated the CNA's should document any skin changes on the shower sheets and communicate any changes to the charge nurse. The ADON stated the staff might not have noticed the change to the residents foot because Resident #1 did not require any assistance with bathing and only required supervision. Interview on 8/27/20 at 10:26 AM with the Treatment Nurse, LVN E revealed he was not aware of an injury or wound to Resident #1's toe. Further interview revealed he did not look at the toe and did not notify any physician about Resident #1's toe because he was not aware of the change in condition. Interview on 8/27/20 at 10:44 AM the DON stated each resident had a skin assessment that was performed weekly and any changes to the skin should be documented in the resident's record. The DON stated her expectations of staff included that any changes in skin would require the CNA

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F 0687 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) to notify the charge nurse. All showers should be documented in PCC. The DON stated that COVID had been overwhelming to the facility and to the staff. The DON was then shown a picture of Resident #1's 3rd toe. The DON indicated she would expect any staff member who was aware of this type of injury or wound to notify the resident's nurse and for the nurse to notify the wound care nurse (Treatment Nurse), the resident's physician and the residents RP of a change in skin condition. The DON indicated the nurse should document in the residents record the wound/injury and continue to monitor. Interview with CNA F on 8/27/20 at 10:12 AM confirmed she had been assigned to showers/baths for Resident #1 for the week of 8/24/20-8/27/20. Further interview revealed she had not assisted Resident #1 with showering/bathing during this time because they staff was moving residents around for COVID preparations. Review of a staff policy titled, Bath, Tub/Shower dated 2003 revealed: Bathing by tub bath or shower is done to remove soil, dead [MEDICATION NAME] cells, microorganisms from the skin and body odor to promote comfort, cleanliness, circulation and relaxation. Goals: The resident will maintain intact skin integrity Review of a facility policy, titled Notifying the Physician of Change in Status dated March 11, 2013 revealed: The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgment deem it necessary for immediate medical attention. 1. The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services to include procedures that assured the accurate dispensing and administering of all drugs to meet the needs of 1 of 1 (Resident #1) residents reviewed for medication administration, in that: LVN B did not administer Resident #1's medications, identified as [MEDICATION NAME] ER 250 mg tablet, [MEDICATION NAME] 40 mg tablet, and [MEDICATION NAME] 40 mg tablet in a manner that ensured they were consumed by the resident. This deficient practice could affect residents with dementia in the facility and could result in a failure to administer medications, inaccuracy in dispensing medications and a risk other residents could access and consume the medications and could result in unwanted side effects, or a decline in health. The findings were: Review of Resident #1's face sheet, dated 8/27/20 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's Care Plan dated 7/22/20 and last updated 7/29/20 revealed the resident had an impaired cognitive function and impaired thought processes related to dementia and metabolic [MEDICAL CONDITION] with interventions which included: Administer meds (medication) as ordered. Review of Resident #1's 5-day admission MDS dated [DATE] revealed a BIM's score of 6 which indicated a severe cognitive impairment with disorganized thinking that changes in severity and comes and goes. Review of Resident #1's MAR for August 2020 revealed physician orders [REDACTED]. Observation on 8/27/20 at 9:10 AM with LVN B revealed 3 pills (identified as [MEDICATION NAME] ER 250 mg tablet, [MEDICATION NAME] 40 mg tablet, and [MEDICATION NAME] 40 mg tablet) located on the residents nightstand. Interview on 8/27/20 at 9:10 AM with LVN B confirmed the 3 pills were left unattended by staff on the resident's nightstand. LVN B indicated she had administered the medications to Resident #1 as part of morning med pass and believed the resident pocketed the medications and did not swallow them. LVN B stated she was supposed to look in the resident's mouth to ensure they had been swallowed and stated she did ask the resident to open her mouth but did not look under the residents tongue. Interview on 8/27/20 at 10:44 AM with the DON confirmed medication should be administered as ordered. Review of a facility policy, titled Medication Administration Procedures: dated 2003 and last revised 10/25/17 revealed: 1. All medications are administered by licensed medical or nursing personnel 2. Medications are to be poured, administered and charted by the same licensed person. 5. After the resident has been identified, administer the medication and immediately chart doses administered on the medication administration record.