

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195281	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER Meadowview Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Meadowview Drive Minden, LA 71055	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record reviews and interviews the provider failed to ensure ADL (Activities of Daily Living) Care was completed for 1 (Resident #1) of 3 sampled residents. Findings:Review of Resident #1's medical record revealed Resident #1 was admitted to the facility on [DATE] and was discharged from the facility on 09/02/2025. Resident #1's diagnoses included Multiple Sclerosis, muscle weakness, seizures, lack of coordination, muscle wasting and atrophy, altered mental status, restlessness and agitation, polyosteoarthritis, Schizoaffective disorder, bipolar type. Review of Resident #1's Minimum Data Set, dated [DATE] revealed Resident #1 required substantial/maximal assistance for bathing. The definition of substantial/maximal assistance meant the helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. Resident #1's BIMS (Brief Interview for Mental Status) score was 15, which would indicate the resident was cognitively intact. Review of Resident #1's Documentation Survey Report for August 2025 revealed no documentation of evidence of bathing being completed on August 19th, 20th, 21st, 22nd, 23rd, 24th, 25th, 26th, 27th, 28th, 29th, 30th, and 31st, of 2025. On the days there was no documentation of evidence of bathing being completed Resident #1 had code 97 entered on the Documentation Survey Report which indicated not applicable.During a telephone interview on 09/22/2025 at 12:50 p.m., Resident #1 reported that she did not receive a bath for two weeks. During an interview on 09/23/2025 at 2:45 p.m., S1DON (Director of Nursing) verified Resident #1 did not receive a bath on August 19th, 20th, 21st, 22nd, 23rd, 24th, 25th, 26th, 27th, 28th, 29th, 30, and 31st of 2025. She further reported code 97 meant not applicable. During an interview on 9/23/25 at 3:30 p.m., S2Corporate Nurse reported the code 97 means not applicable, and that code should not be used. S2Corporate Nurse verified that code 97 should be the same as not getting bathed. During an interview on 09/25/2025 at 11:55 a.m., S3CNA (Certified Nursing Assistant) reported Resident #1 required assistance for bathing. During an interview on 09/25/2025 at 12:20 p.m., S4CNA reported Resident #1 required assistance for bathing. During an interview with observation on 09/25/2025 at 1:15 p.m., S5CNA reported they use a Kiosk for documenting all care that resident's receive. Observation with S5CNA revealed several different options to select for bathing according to resident's needs. Further review revealed an option of Not Applicable. During an interview on 09/25/2025 at 1:40 p.m. S1DON verified the staff uses the Kiosk to document what they have completed for each resident they are responsible for.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 195281	If continuation sheet Page 1 of 1