STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195281	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowview Health & Rehab Center	400 Meadowview Drive Minden, LA 71055

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure residents were free from psychosocial harm and physical restraints used for the purpose of discipline or convenience that were not required to treat the residents' medical conditions for 2 (#1, #2) of 5 (#1, #2, #3, #4, #5) sampled residents. The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. Findings:Review of the facility's policy title: Facility Policy on PSDs (Personal Safety Devices) -Enablers-Side Rails-Restraints-Involuntary Seclusion Revised March 2026 revealed, in part:Restraint Policy Intent:Patients/Residents have the right to be free from any physical restraint imposed for purposes of discipline or convenience and when not required to treat the patient's/resident's medical condition. Patients/Residents have the right to function at their highest practicable level in the least restrictive environment possible.Policy:Restraints will not be used unless the facility's Interdisciplinary Team has completed an assessment and evaluation to identify causative medical or environmental factors and considered less restrictive alternatives (except in an emergency).Restraints will never be used for discipline or staff convenience.Definitions: A physical restraint is any manual method, or physical, or mechanical device, material or equipment attached or adjacent to a patient's/resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Convenience is defined as any action taken by the facility to control patient/resident behavior or maintain patients/residents with a lesser amount of effort by the facility and not in the patient's/resident's best interest. Resident #1Review of Resident #1's medical record revealed an initial admission date to the facility on [DATE] and an admission date of 11/27/2024 to the facility's memory care unit. Further review of Resident #1's medical record revealed diagnoses including, in part: Alzheimer's disease with late onset, unspecified dementia . with other behavioral disturbance, cognitive communication deficit, major depressive disorder recurrent, anxiety disorder, Schizophrenia unspecified, acute ischemic heart disease unspecified, and muscle wasting and atrophy not elsewhere classified of right and left upper arm. Review of Resident #1's 02/21/2026 Quarterly MDS (Minimum Data Set) revealed a BIMS (Brief Interview Mental Status) of 06, indicating severe impaired cognition. Resident #1 required substantial/maximal assistance with sit to stand and chair/bed-to-chair transfer. Review of Resident #1's Comprehensive Care Plan revealed Resident #1 was care planned for Behavior problem with resident attempting to stand from wheelchair with interventions that included, in part, anticipate and meet the resident's needs and redirect as needed. During a phone interview on 05/12/2026 at 12:20 p.m. S5 CNA reported she worked on the memory care unit and did not remember the day, but recently, had put a sheet around Resident #1's abdomen, ran it through the sides of the wheelchair and tied it in the back of the wheelchair to secure him, as he had falls and was trying to get up. S5 CNA further reported Resident #2 continued to try to get up once the sheet was placed, but could not and eventually stopped trying to get up. Resident #2 Review of Resident #2's medical record revealed an initial admission date to the facility on [DATE] and an admission date of 03/16/2026 to the facility's memory care unit. Further review of Resident #2's (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medical record revealed diagnoses that included, in part: Alzheimer's disease with late onset, insomnia unspecified, cognitive communication deficit, impulsiveness, disorientation, major depressive disorder recurrent, and vascular dementia severe with agitation. Review of Resident #2's 03/10/2026 admission MDS revealed a BIMS of 0, indicating severe impaired cognition. Resident #2 was dependent with sit to stand and supervision or touching assistance with chair/bed to chair transfers. Review of Resident #2's Comprehensive Care Plan revealed a care plan for Wandering risk with interventions that included, in part, provide me with re-orientation as needed. During a phone interview on 5/12/2026 at 4:14 p.m. S7 CNA reported she worked outside the memory care unit but would assist some in memory care unit and she did not remember the exact date but one recent evening she and S4 CNA went to the memory care unit to assist residents to bed and when S4 CNA tried to put Resident #2 to bed, she saw Resident #2 had a sheet tied around her and the wheelchair. S7 CNA further reported Resident #2 should not have been tied to her chair. During an interview on 05/13/2026 at 08:30 a.m. S2 DON (Director of Nursing) reported S8 CNA had reported to her on the morning of 04/15/2026 that she had overheard a conversation between S4 CNA and S7 CNA saying that they had seen a resident who was tied to their wheelchair with a sheet on 04/13/2026 in the memory care unit. During a phone interview on 05/13/2026 at 10:44 a.m. S4 CNA reported she worked outside the memory care unit and on 04/13/2026 around 9:00 p.m. she and S7 CNA were called to assist 2 memory care residents who were roommates to bed. S4 CNA further reported while trying to transfer Resident #2 from her wheelchair to bed, the chair came up with Resident #2 and she saw Resident #2 had a sheet around the abdomen and tied behind the wheelchair. S4 CNA further reported Resident #2 should not have been tied to her chair. During a phone interview on 05/13/2026 at 4:43 p.m. S6 LPN reported she could not remember the exact day but around the end of March 2026 she came in for her night shift and saw Resident #1 and Resident #2 restrained to their wheelchairs with a sheet around each of their abdomens and tied in the back behind their wheelchairs. S6 LPN further reported she told staff it was wrong to tie residents up. During an interview on 05/13/2026 at 3:30 p.m. S2 DON confirmed restraints should not have been used on any residents. During an interview on 05/14/2026 at 7:45 a.m. S1 Administrator reported Resident #1 and Resident #2 should not have been restrained in any way. During an interview on 05/14/2026 at 1:40 p.m. S1 Administrator confirmed a reasonable person who was restrained as Resident #1 and Resident #2 were, would have experienced psychosocial harm.During the survey, in-service records and QA monitoring records were reviewed and it was determined that the facility had implemented the following actions to correct deficient practice.Review of facility's corrective actions to deficient practice with a completion date of 04/22/2026 included:Intervention:1. Address how corrective actions were accomplished for those residents found to have been affected by the deficient practice.-04/15/2026 at 1:24am allegation received. -Employee responsible for Resident #2's restraint placement on 4/13/2026 was unknown. -Staff on 4/13/2026 memory care night shift (S6 LPN, S5 CNA) and day shift (S3 LPN, S9 CNA) were suspended pending investigation. -S7 CNA resigned after giving her statement on 4/15/2026.-After investigation S5 CNA and S6 LPN were terminated-Through interviews on 4/15/2026, S5 CNA admitted to restraining Resident #1 in recent past, but not on 4/13/2026.-Police department was notified and came to facility 4/15/2026.-Skin audits for Resident #1 and Resident #2 were conducted by Treatment Nurse on 4/15/2026. 2. Describe how other residents with potential to be affected will be identified and what will be done for them:-All residents in Meadows memory care unit were assessed for injury on 4/15/2026 and none were noted.-All residents in Meadows memory care unit were placed on every 30 minutes monitoring for restraint use for 72 hours beginning 4/15/2026 and completed on 4/18/2026.-Investigation interviews regarding whether staff had seen anyone restrained began with all staff members on Main on 4/15/2026 and interviews were completed on 4/16/2026. None of the staff interviewed were aware of anyone being restrained except S6 LPN who found 2 residents in memory care restrained, S4 CNA and S7 CNA who saw Resident #2 restrained in the memory care unit, and S5 CNA who reported she had restrained Resident #1.-Visual check of ALL (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rooms and residents by Administrator, Activities Director, Admissions coordinator, BOM (Business Office Manager) for signs of restraint use on 4/15/2026 and none were by staff found.-Resident Life Satisfaction rounds/surveys were completed for residents the administrator reported had a cognitive BIMS score by the Social Services staff with no negative findings on 4/15/2026. Each of the residents who answered questions for the Life Satisfaction Survey were noted to be outside of the memory care unit.-PEER surveys were completed by Social Services staff on 4/15/2026 and 4/20/2026 in regard to the 4 suspended employees with no negative findings completed on 4/20/2026.-Care Plans for the 17 memory care residents were reviewed by the interdisciplinary team of MDS Nurses and DON for resident's behaviors, fall risk and current interventions with completion date of 4/15/2026. 3. Measures that will be put in place or system changes that will be made to ensure practice will not recur:-S1 Administrator reported on 5/11/2026 at 4:00pm that all staff had abuse training on 04/14/2026 and prior to being aware of this issue.-Leadership rounds by MDS nurses and ADON (Assistant Director of Nursing) staff to observe staff response to residents and interview staff response to residents with impulsive or high-risk behaviors for 4 weeks started on 04/16/2026 with completion date of 05/08/2026.-In-services for all staff -Restraint specified based on policy and procedure by S1 Administrator began on 4/15/2026 for all staff with the addition of more specific in-service regarding restraining residents, appropriate escalation to nursing and leadership, and managing impulsive behaviors with knowledge verification on 4/15/2026. Completion date of 4/22/2026.-On 4/21/2026 In-service material on managing impulsive behaviors and resident safety was added to new employee orientation materials and is ongoing.-On 4/22/2026 Fall prevention strategies was sent to all staff via messaging platform and was posted in the memory care unit. 4. Indicate how the facility plans to monitor its performance to ensure solutions are sustained. Plan for ensuring corrective action is achieved and sustained. How corrective measures will be monitored. What QA (Quality Assurance) program will be put in place (who, how, how often, what will be done if problems discovered?)-Monitoring of all residents for restraint use by non-biased nurses that do not work on the memory care unit twice a day began on 04/15/2026 and is ongoing.-Weekly review of monitoring tools and residents were conducted in the AM meeting with all disciplines to identify any opportunities for further education/disciplinary actions for 8 weeks started 04/15/2026 and is ongoing. Validation of review of facility's actions to correct deficient practice:1. Address how corrective actions were accomplished for those residents found to have been affected by the deficient practice.-Review of facility's time sheet for S5 CNA, S9CNA, S3 LPN, and S6 LPN who were suspended pending investigation revealed last work date of 04/14/2026.-S7 CNA resignation letter noted on 04/15/2026.-Documents revealed S5 CNA and S6 LPN were terminated with last work date of 04/14/2026.-Review of Investigation interview statements revealed S5 CNA admitted to restraining Resident #1 and S6 admitted to seeing Residents #1 and #2 restrained.-Review of Resident #1 and #2's skin audits on 04/15/2026 revealed no new skin problems. 2. Describe how other residents with potential to be affected will be identified and what will be done for them:-Review of all memory care unit skin audits on 04/15/2026 revealed no new skin problems.-Review of documentation revealed each of the 17 residents on the memory care unit were monitored every 30 minutes for 72 hours beginning on 04/15/2026 and completed on 4/18/2026.-Reviewed facility map with which supervisor was responsible for which sections for restraint search with no issues found.-Review of Life Satisfaction rounds for allegation of restraint with 10 residents who were cognitively intact was conducted on 04/15/2025 and revealed no issues. -Review of documented Peer Review for restraint use by Social Services Staff on 04/17/2026 and 04/20/2026 with no issues found.-During interview on 05/13/2026 at 4:18 p.m. S10 MDS reported the MDS nurses reviewed the memory care residents care plans for any interventions needed. 3. Measures that will be put in place or system changes that will be made to ensure practice will not recur:-Reviewed documentation of 04/14/2025 training for all staff by the administrator in regard to resident abuse, reporting of abuse, resident rights, compliance and ethics and communication.-Reviewed documentation of leadership rounds, each with different (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident on the locked unit, conducted at least weekly and indicated appropriate responses. -Reviewed training documentation in regard to restraints, policy, reporting, and managing impulsive behaviors which started on 04/15/2026 and was completed on 04/22/2026.-Reviewed documentation of 04/15/2026 training for S4 CNA regarding immediate notification of Administrator and DON when a resident is seen restrained.-Interviews were conducted with multiple staff throughout the course of the survey from 05/11/2026 to 05/18/2026 revealed staff had received in-service training in regard to abuse, use of restraints, reporting, and managing behaviors. During the interviews staff reported restraints were not to be used and they knew to report immediately to the DON or administrator when residents seen with restraint. 4. Indicate how the facility plans to monitor its performance to ensure solutions are sustained. Plan for ensuring corrective action is achieved and sustained. How corrective measures will be monitored. What QA program will be put in place (who, how, how often, what will be done if problems discovered?)-During an interview on 05/14/2026 at 12:25 p.m. S1 Administrator reported ADHOC (to this) QAPI (Quality Assurance and Performance Improvement) with MD (Medical Doctor) and team on restraints and managing impulsive behaviors and resident safety skill was conducted on 04/15/2026. S1 Administrator further reported weekly review of monitoring tools and residents were conducted in the morning meeting with all disciplines present to identify any opportunities for further education/disciplinary actions for 8 weeks started 04/15/2026 and is ongoing. S1 Administrator further reported managing of behaviors training/testing was added to new hire orientation training.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and interviews the facility failed to ensure staff reported alleged violations of abuse for the use of physical restraints to the administrator immediately or within 2 hours for 2 (#1, #2) of 5 (#1, #2, #3, #4, #5) sampled residents. The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a Past Noncompliance citation. Findings:Review of policy titled Abuse Prohibition Policy reviewed and revised 02/26/2026 revealed, in part:INTENT:This protocol was intended to assist in the prevention of abuse, neglect and misappropriation of property.Each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion and financial abuse.POLICY:1. The facility will prohibit neglect, mental or physical abuse, including involuntary seclusion and the misappropriation of property or finances of residents.DEFINITIONS:Abuse means the willful infliction of injury, withholding or misappropriating property or money, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.Reporting/Response:1. Any employee who becomes aware of an allegation of abuse, neglect or misappropriation of resident property, shall report the incident to the Abuse Coordinator immediately. Failure to do so will result in disciplinary action, up to and including termination. Resident #1Review of Resident #1's medical record revealed an initial admission date to the facility on [DATE] and an admission date of 11/27/2024 to the facility's memory care unit. Further review of Resident #1's medical record revealed diagnoses including, in part: Alzheimer's disease with late onset, unspecified dementia . with other behavioral disturbance, cognitive communication deficit, major depressive disorder recurrent, anxiety disorder, Schizophrenia unspecified, acute ischemic heart disease unspecified, and muscle wasting and atrophy not elsewhere classified of right and left upper arm. Review of Resident #1's 02/21/2026 Quarterly MDS (Minimum Data Set) revealed a BIMS (Brief Interview Mental Status) of 06, indicating severe impaired cognition. During a phone interview on 05/12/2026 at 12:20 p.m. S5 CNA reported she worked on the memory care unit and did not remember the day, but recently, had put a sheet around Resident #1's abdomen, ran it through the sides of the wheelchair and tied it in the back of the wheelchair to secure him in the wheelchair. S5 CNA further reported she did not immediately report to anyone that Resident #1 had a restraint on. Resident #2 Review of Resident #2's medical record revealed an initial admission date to the facility on [DATE] and an admission date of 03/16/2026 to the facility's memory care unit. Further review of Resident #2's medical record revealed diagnoses that included, in part: Alzheimer's disease with late onset, insomnia unspecified, cognitive communication deficit, impulsiveness, disorientation, major depressive disorder recurrent, and vascular dementia severe with agitation. Review of Resident #2's 03/10/2026 admission MDS revealed a BIMS of 0, indicating severe impaired cognition. During a phone interview on 5/12/2026 at 4:14 p.m. S7 CNA reported she worked outside the memory care unit and she did not remember the exact date but one recent evening she and S4 CNA went to the memory care unit to assist residents to bed and when S4 CNA tried to put Resident #2 to bed, she saw Resident #2 had a sheet tied around her and the wheelchair. S7 CNA further reported she did not immediately report that Resident #2 was restrained to her wheelchair to anyone. During an interview on 05/13/2026 at 08:30 a.m. S2 DON (Director of Nursing) reported S4 CNA and S7 CNA did not immediately report seeing Resident #2 restrained to her wheelchair immediately when they saw it on 04/13/2026 and should have. S2 DON further reported S6 LPN did not immediately report to the DON or Administrator when she saw Residents #1 and #2 restrained to their wheelchairs around the end of March and should have. S2 DON also reported S5 CNA did not immediately report when she restrained Resident #1 in the recent past and should have. During a phone interview on 05/13/2026 at 10:44 a.m. S4 CNA reported she worked outside the memory care unit and on 04/13/2026 around 9:00 p.m. she and S7 CNA were called to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assist 2 memory care residents to bed and while trying to transfer Resident #2 from her wheelchair to bed, she saw Resident #2 had a sheet around the abdomen and tied behind the wheelchair. S4 CNA further reported she did not immediately report that Resident #2 was restrained to her wheelchair. During a phone interview on 05/13/2026 at 4:43 p.m. S6 LPN reported she could not remember the exact day but around the end of March 2026 she saw Resident #1 and Resident #2 restrained to their wheelchairs with a sheet around each of their abdomens and tied in the back behind their wheelchairs. S6 LPN further reported she did not immediately report Resident #1 and #2 being found restrained to their wheelchair. During an interview on 05/14/2026 at 1:40 p.m. S1 Administrator reported when any resident was found restrained as Resident #1 and #2 were, it should have been reported to administration immediately and in this case was not. S1 Administrator further confirmed a reasonable person who was restrained as Resident #1 and Resident #2 were, would have experienced psychosocial harm. During the survey, in-service records and QA (Quality Assurance) monitoring records were reviewed and it was determined that the facility had implemented the following actions to correct deficient practice.Review of facility's corrective actions to deficient practice with a completion date of 04/22/2026 included:Intervention:1. Address how corrective actions were accomplished for those residents found to have been affected by the deficient practice.-04/15/2026 at 1:24am allegation received. -Employee responsible for Resident #2's restraint placement on 4/13/2026 was unknown. -Staff on 4/13/2026 memory care night shift (S6 LPN, S5 CNA) and day shift (S3 LPN, S9 CNA) were suspended pending investigation. -S7 CNA resigned after giving her statement on 4/15/2026.-After investigation S5 CNA and S6 LPN were terminated-Through interviews on 4/15/2026, S5 CNA admitted to restraining Resident #1 in recent past, but not on 4/13/2026.-Police department was notified and came to facility 4/15/2026.-Skin audits for Resident #1 and Resident #2 were conducted by Treatment Nurse on 4/15/2026. 2. Describe how other residents with potential to be affected will be identified and what will be done for them:-All residents in Meadows memory care unit were assessed for injury on 4/15/2026 and none were noted.-All residents in Meadows memory care unit were placed on every 30 minutes monitoring for restraint use for 72 hours beginning 4/15/2026 and completed on 4/18/2026.-Investigation interviews regarding whether staff had seen anyone restrained began with all staff members on Main on 4/15/2026 and interviews were completed on 4/16/2026. None of the staff interviewed were aware of anyone being restrained except S6 LPN who found 2 residents in memory care restrained, S4 CNA and S7 CNA who saw Resident #2 restrained in the memory care unit, and S5 CNA who reported she had restrained Resident #1.-Visual check of ALL rooms and residents by Administrator, Activities Director, Admissions coordinator, BOM (Business Office Manager) for signs of restraint use on 4/15/2026 and none were by staff found.-Resident Life Satisfaction rounds/surveys were completed for residents the administrator reported had a cognitive BIMS score by the Social Services staff with no negative findings on 4/15/2026. Each of the residents who answered questions for the Life Satisfaction Survey were noted to be outside of the memory care unit.-PEER surveys were completed by Social Services staff on 4/15/2026 and 4/20/2026 in regard to the 4 suspended employees with no negative findings completed on 4/20/2026.-Care Plans for the 17 memory care residents were reviewed by the interdisciplinary team of MDS Nurses and DON for resident's behaviors, fall risk and current interventions with completion date of 4/15/2026. 3. Measures that will be put in place or system changes that will be made to ensure practice will not recur:-S1 Administrator reported on 5/11/2026 at 4:00pm that all staff had abuse training on 04/14/2026 and prior to being aware of this issue.-Leadership rounds by MDS nurses and ADON (Assistant Director of Nursing) staff to observe staff response to residents and interview staff response to residents with impulsive or high-risk behaviors for 4 weeks started on 04/16/2026 with completion date of 05/08/2026.-In-services for all staff -Restraint specified based on policy and procedure by S1 Administrator began on 4/15/2026 for all staff with the addition of more specific in-service regarding restraining residents, appropriate escalation to nursing and leadership, and managing impulsive behaviors with knowledge verification (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 4/15/2026. Completion date of 4/22/2026.-On 4/21/2026 In-service material on managing impulsive behaviors and resident safety was added to new employee orientation materials and is ongoing.-On 4/22/2026 Fall prevention strategies was sent to all staff via messaging platform and was posted in the memory care unit. 4. Indicate how the facility plans to monitor its performance to ensure solutions are sustained. Plan for ensuring corrective action is achieved and sustained. How corrective measures will be monitored. What QA (Quality Assurance) program will be put in place (who, how, how often, what will be done if problems discovered?)-Monitoring of all residents for restraint use by non-biased nurses that do not work on the memory care unit twice a day began on 04/15/2026 and is ongoing.-Weekly review of monitoring tools and residents were conducted in the AM meeting with all disciplines to identify any opportunities for further education/disciplinary actions for 8 weeks started 04/15/2026 and is ongoing. Validation of review of facility's actions to correct deficient practice:1. Address how corrective actions were accomplished for those residents found to have been affected by the deficient practice.-Review of facility's time sheet for S5 CNA, S9CNA, S3 LPN, and S6 LPN who were suspended pending investigation revealed last work date of 04/14/2026.-S7 CNA resignation letter noted on 04/15/2026.-Documents revealed S5 CNA and S6 LPN were terminated with last work date of 04/14/2026.-Review of Investigation interview statements revealed S5 CNA admitted to restraining Resident #1 and S6 admitted to seeing Residents #1 and #2 restrained.-Review of Resident #1 and #2's skin audits on 04/15/2026 revealed no new skin problems. 2. Describe how other residents with potential to be affected will be identified and what will be done for them:-Review of all memory care unit skin audits on 04/15/2026 revealed no new skin problems.-Review of documentation revealed each of the 17 residents on the memory care unit were monitored every 30 minutes for 72 hours beginning on 04/15/2026 and completed on 4/18/2026.-Reviewed facility map with which supervisor was responsible for which sections for restraint search with no issues found.-Review of Life Satisfaction rounds for allegation of restraint with 10 residents who were cognitively intact was conducted on 04/15/2025 and revealed no issues. -Review of documented Peer Review for restraint use by Social Services Staff on 04/17/2026 and 04/20/2026 with no issues found.-During interview on 05/13/2026 at 4:18 p.m. S10 MDS reported the MDS nurses reviewed the memory care residents care plans for any interventions needed. 3. Measures that will be put in place or system changes that will be made to ensure practice will not recur:-Reviewed documentation of 04/14/2025 training for all staff by the administrator in regard to resident abuse, reporting of abuse, resident rights, compliance and ethics and communication.-Reviewed documentation of leadership rounds, each with different resident on the locked unit, conducted at least weekly and indicated appropriate responses. -Reviewed training documentation in regard to restraints, policy, reporting, and managing impulsive behaviors which started on 04/15/2026 and was completed on 04/22/2026.-Reviewed documentation of 04/15/2026 training for S4 CNA regarding immediate notification of Administrator and DON when a resident is seen restrained.-Interviews were conducted with multiple staff throughout the course of the survey from 05/11/2026 to 05/18/2026 revealed staff had received in-service training in regard to abuse, use of restraints, reporting, and managing behaviors. During the interviews staff reported restraints were not to be used and they knew to report immediately to the DON or administrator when residents seen with restraint. 4. Indicate how the facility plans to monitor its performance to ensure solutions are sustained. Plan for ensuring corrective action is achieved and sustained. How corrective measures will be monitored. What QA program will be put in place (who, how, how often, what will be done if problems discovered?)-During an interview on 05/14/2026 at 12:25 p.m. S1 Administrator reported ADHOC (to this) QAPI (Quality Assurance and Performance Improvement) with MD (Medical Doctor) and team on restraints and managing impulsive behaviors and resident safety skill was conducted on 04/15/2026. S1 Administrator further reported weekly review of monitoring tools and residents were conducted in the morning meeting with all disciplines present to identify any opportunities for further education/disciplinary actions for 8 weeks started 04/15/2026 and is (continued on next page)

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	195281	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowview Health & Rehab Center	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ongoing. S1 Administrator further reported managing of behaviors training/testing was added to new hire orientation training.