STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455455	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Care of Alice	218 219 N King St Alice, TX 78332

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 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 observation, interview, and record review, the facility failed to ensure the resident was treated with respect and dignity and care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 (Resident #1) of 7 residents reviewed for dignity and respect, in that: LVN A spoke to Resident #1 in front of other residents, in the dining room, about Resident #1 sitting in the dining room in his underwear, making Resident #1 feel embarrassed. This failure could place residents at risk for embarrassment, isolation, and possible depression.The findings include: Record review of Resident #1's Face Sheet dated 09/30/25 documented a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of: Muscle Wasting and Atrophy(The loss of skeletal muscle mass.) , Heart Failure (A chronic condition in which the heart doesn't pump blood as well as it should.), Type 2 Diabetes (A chronic condition in which the body does not use insulin properly or does not produce enough insulin), Hypertension (a condition where the force of blood against the artery walls is consistently too high.), Chronic Obstructive Pulmonary (disease a group of lung diseases that cause airflow obstruction and breathing problems). Record review of Resident #1's Care Plan Dated 09/30/25 revealed requires assistance with activities of daily life, is at risk for shortness of breath related to Chronic Obstructive Pulmonary Disease, at risk for injury related to alteration in vision, at risk for falls, being treated for my hyperlipidemia and encourage to exercise and the resident is encouraged to participate in activities that will not depend on major physical exertion and encourage to get out of bed daily. Record review on 09/30/25 of Resident #1's MDS dated [DATE] revealed resident had a BIMS score of 15 which indicated intact cognition, meaning the individual's cognitive function, including memory and orientation, appears normal and unimpaired according to the scale's criteria. The Functional Abilities section indicated resident was independent no need for assistance. Record Review of Resident #1's progress note dated 09/06/25 revealed CNA B was concerned with Resident #1's sadness and depressed demeaner so CNA B asked Resident #1 what was wrong and Resident #1 stated he did not want to discuss anything with CNA B. The weekend manager was the SSA and she was notified of the incident that occurred between LVN A and Resident #1 that day. The incident involved LVA A who told Resident #1 in front of the other residents that he was wearing underwear briefs to bingo and needed to go change. The SSA was prompt in addressing the incident so it could be further investigated. In an interview on 09/30/25 at 2:30 PM with the Abuse Coordinator/ Administrator she stated Resident #1 was approached by a LVN A and Resident #1 was asked if he knew he had no pants on. The AC/Admin stated LVN A preceded to ask Resident #1 if he could go put on some clothes over his underwear briefs because there were female residents present in the dining room playing bingo. Resident#1 was helped to his room, and he never returned to the dining room that day. The AC/Admin stated she followed up on Resident#1 the next day to see if he had any issues with the way he was approached and he stated he had forgotten about it and was water under the bridge. The AC/Admin Stated she went a second time to follow up on the resident and he was fine and had no issues with staff or facility. In an Interview on 09/30/25 at 2:51 PM LVN A she stated the residents were playing bingo and Resident #1 was sitting playing in his underwear. LVN A stated she went up to Resident #1 and asked him if he knew that he had no pants. LVN A stated Resident #1 said he knew he did not have pants. LVN A asked Resident #1 if he could go put some pants on. LVN A stated Resident #1 was escorted to the room, and he never came back. LVN A stated she told him there were female resident in the dining room and Resident #1 said he did not care. LVN A stated she probably should have told him in a more privately manner instead of in front of the whole table. LVN A said she had not approached another resident in that manner again since the one incident in the dining room with Resident #1. LVN A stated she has a good rapport with Resident#1 and there was no ill will between them. The last time they had a training on Resident Rights was about 4 to 6 months ago. In an interview 09/30/25 4:41 PM with the Social Services Assistant she was the manager on duty that day doing rounds the CNA B had a concern with the Residents #1 and a LVN staff member. CNA B stated LVN A yelled at Resident #1 about him not wearing pants in the dining room with other residents playing bingo. The SSA stated Resident #1 told her about what LVN A had done and LVN A was just doing her job. The SSA stated the other residents in the dining room thought they were shorts and had no problem with him in the dining room dressed that way. The SSA stated Resident#1 told her he felt belittled after the LVN A spoke to him, so he went to his room. The SSA stated Resident #1 told her he had no clothes that fit him at the time of the