

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455455	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Meridian Care of Alice		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** 46038 Based on interview, record review and observation, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet a resident's medical and nursing needs to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 6 residents (Resident #100), reviewed for care plans. The facility failed to implement and ensure Resident #100 had 2 beveled mats on floor as care planned dated 10/25/24. This deficient practice could place residents in the facility at risk of not being provided with the necessary care or services and implementing personalized plans developed to address their specific needs. The Findings included: Record review of Resident #100's face sheet dated 1/15/25 reflected a [AGE] year-old-male with an original admitted [DATE]. Diagnoses included Dementia (decline in cognitive abilities that affects a person's ability to perform everyday activities), hypertension (high blood pressure), and unsteadiness on feet. Record review of Resident #100's care plan dated 10/25/24 stated Resident #100 was at risk for falls due to unsteadiness on feet. Interventions included 2 beveled mats. Record review of Resident #100's annual MDS dated [DATE] reflected a BIM score of 2 (severe cognitive impairment), utilized a wheelchair, and required partial/moderate assistance with sitting/standing and chair/bed transfers. During an observation on 01/14/25 at 02:55 PM Resident was asleep in bed with one floor mat noted to right side of the bed. During an observation on 01/15/25 at 01:50 PM Resident was in bed. One floor mat noted to right side of the bed. (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/15/25 at 01:52 PM LVN C stated Resident #100 should have had two floor mats at bedside for fall precautions as Resident #100 had a history of sliding himself off the bed. LVN C stated she was not sure why Resident #100 did not have two floor mats but would immediately get another floor mat to have at Resident #100's bedside. LVN C stated Resident #100 needed two floor mats at bedside to prevent possible injury in case of a fall. In an interview on 01/15/25 at 01:54 PM CNA D stated Resident #100 was supposed to have two floor mats for fall precautions. CNA D stated if she saw only one floor mat at Resident #100's bedside, she would have reported it to the nurse immediately. CNA D stated she did not notice there was only one floor mat as that side of the bed is was closer to the wall and she usually assists Resident #100 on the right side of the bed. CNA D stated she was not sure why Resident #100 only had one floor mat but was going to get another one. CNA D stated Resident #100 needed a floor mat at each side of the bed to help prevent possible injury in case of a fall. In an interview on 01/15/25 at 04:35 PM the DON stated Resident #100 should have had two floor mats at bedside due to having a care plan that was person centered and should be followed for the resident's safety. The DON stated by not having two floor mats then Resident #100 could potentially have an injury if he sustained a fall. The DON stated the nursing managers are responsible for making sure care plans are implemented and followed. The DON stated she was going to in-service staff immediately on implementation of care plans. Record review of facility's Care Plans, Comprehensive Person-Centered Policy dated 3/2022 stated: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment;		

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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** 50039 Based on observation, interviews and record reviews, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 of 3 residents (Resident #67) reviewed for pharmacy services. The facility failed to ensure Resident #67's physician order for Latanoprost Ophthalmic Solution (eye drops) were administered at bedtime as ordered. This failure could place residents at risk for non-therapeutic responses to medications. Findings included: Record review of Resident #67's face sheet dated 01/16/25 revealed a [AGE] year-old female with an initial admitted [DATE] and a current admitted [DATE]. Pertinent diagnoses included dementia and glaucoma (fluid buildup in the front part of the eye, causing increased pressure and damage to the optic nerve). Record review of Resident #67's Comprehensive MDS assessment section C, cognitive patterns, dated 11/09/24 revealed a BIMS score of 1 (severe impairment). Record review of Resident #67's care plan revised 11/14/24 revealed the focus I have impaired vision r/t diabetes and glaucoma. I wear glasses. I am at risk for injury r/t decreased visual field. DX: Glaucoma. Interventions listed for the focus included: - Administer eye drops as ordered (if ordered); - Encourage independence of ADL's and provide support as needed; - Keep environment free from small objects on floor, very hot liquids, and other hazardous items; - Monitor for eye pain/discomfort & report to MD. Record review of Resident #67's order summary revealed an active order dated 11/03/23 for Latanoprost Ophthalmic Solution 0.005% (Latanoprost). Instill 1 drop in both eyes one time a day for glaucoma. During an observation of medication administration at 7:39 AM on 01/15/25, this state surveyor observed MA A instill 1 drop of Latanoprost Ophthalmic Solution 0.005% in both eyes of Resident #67. The pharmacy label on the Latanoprost read as follows: Instill 1 drop into both eyes at bedtime. Wait 3-5 minutes between drops. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with MA A at 7:41 AM on 01/15/25, MA A stated she did not notice that the label on the medication stated to give the eyedrops at bedtime. MA A stated she had given the eyedrops to Resident #67 in the morning for as long as she could remember. MA A stated she compared the name of the resident, the name of the drug and the number of drops on the label to what was written on her computer and those all matched. MA A stated it was important to follow orders as written by the doctor. MA A stated when she saw a label was mismatched with what the computer showed then she would inform her nurse about the discrepancy. In an interview with RN B at 9:23 AM on 01/15/25, RN B stated it was important to follow doctor's orders as prescribed for the safety and health of the resident. RN B stated if the MA saw a discrepancy between the label on the medication and the order in the computer then they should hold the medication and inform the nurse. RN B stated if there was any discrepancy in an order, she would call the doctor to verify what the proper dose, route, and timing of the medication was. RN B stated she would put a change in direction sticker on the pill package to correct the error. In an interview with the DON at 9:43 AM on 01/16/25, the DON stated before any medication was administered, the employee should make sure the label matched what the order showed in the computer. The DON stated if the MA saw a discrepancy from the label to what the computer showed they should notify the nurse. The DON stated the nurse should then look into the resident's chart to see if they could determine which order was correct and notify the physician to clarify. The DON stated the nurse should instruct the MA to put a change in direction sticker on the label of the medication and call the pharmacy to order a new label or new medication. The DON stated medications were prescribed for a reason and for it to be effective it needed to be administered how the physician asked it to be. The DON stated the nurse that received the order copied it into the computer. The DON stated they reviewed new orders every day in their morning meetings. Record review revealed the facility policy titled Administering Medications revised April 2019 stated the following: Medications are administered in a safe and timely manner, and as prescribed. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.		