

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER The Meadows Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8383 Meadow Rd Dallas, TX 75231	

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)
<p>F 0583</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786</p> <p>Based on interview and record review, the facility failed to ensure residents have a right to personal privacy for 1 of 6 residents (Resident #1) reviewed for privacy.</p> <p>1. Facility staff allowed a visitor to sign in as a volunteer, but was not an approved volunteer. Visitor recorded Resident #1, while at the facility and posted the recording to social media.</p> <p>This deficient practice could place residents at-risk of loss of dignity due to lack of privacy.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet, dated 12/06/24, reflected a [AGE] year-old female, who admitted to the facility on [DATE]. Resident #1 had a diagnosis of Mood Disorder (mental illness that affects a person's emotional state), Insomnia (have trouble falling asleep or staying asleep), Essential Hypertension (high blood pressure), and Restlessness and Agitation.</p> <p>Record review of Resident #1's Admission MDS Assessment, dated 10/16/24, reflected Resident #1 had a BIMS score of 05, which indicated Resident #1 was severely impaired.</p> <p>Record review of video #1, posted online on 11/30/24, reflected the Activities Assistant as she spoke to Resident #1 reflected the Activities Assistant as she asked the Visitor Why does she (Resident #1) have so many (cupcakes), did you give her those. The visitor asked, She asked for two, can she not have two?. The Activities Assistant can then be heard telling the visitor, She (Resident #1) will make a pig out of herself so don't. The Visitor and Resident #1 sat at the table together at the time of the conversation.</p> <p>(continued on next page)</p>

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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<p>F 0583</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of video #2, posted online on 11/30/24, reflected the Activities Assistant was at one table, and Resident #1 was at a table near the Activities Assistant. The residents were in the dining hall of memory care watching a movie. The Activities Assistant can be heard asking Resident #1, Why don't you go wash your hands?, Resident #1 replied, I am just teasing her (The Visitor), and the Activities Assistant replied to Resident #1, Go wash your hands. Look at the mess you made. An unknown person in the background stated, It's messy, and Activities Assistant can be heard saying, It is. Resident #1 can be seen rolling up the cupcake papers and napkins and stated to the Activities Assistant, I'll go. Resident #1 asked the Activities Assistant, Where can I wash at, and Activities Assistant replied, Try your room, as she starred at Resident #1. Resident #1 replied, Okay, no problem. I messed up. I have to clean up. Resident #1 was observed gathering the crumbs from the cupcake off the table.</p> <p>In an interview on 12/06/24 at 9:45 AM, Resident #1 stated she was having a good morning, as she sat and spoke with other residents in the dining hall of memory care. When Surveyor asked Resident #1 about Thanksgiving, Resident #1 just started Thanksgiving was good. Resident #1 stated the staff were good and she was treated well. Resident #1 did not remember anything specific about Thanksgiving when Surveyor asked.</p> <p>In a telephone interview on 12/06/24 at 11:00 AM, Resident #1's Family Member stated she was very mad and upset when she saw the video on social media. The family member stated she and other family members were upset that someone filmed Resident #1, and then it was uploaded to a public, social media application. The Family Member stated Resident #1 did not really remember the incident, but she could only remember eating the cupcakes. The Family Member stated she was upset Resident #1 was recorded in several videos. The Family Member stated the family contacted the DON and asked for the DON to meet them at the facility. The Family Member stated they sent the videos to the DON, and the DON stated she would have been upset as well. The Family Member stated she was not sure how the visitor got in the building, the staff told her they were still investigating to see who the visitor was and why she recorded the videos. The Family Member stated the DON stated the staff were not aware the visitor was recording the resident.</p> <p>In an interview on 12/06/24 at 12:40 PM, the DON stated the facility only had a policy regarding staff and electronic monitoring or rules for visitors, but she would research to confirm there was no other policy.</p> <p>In an interview on 12/06/24 at 3:22 PM, the DON stated no residents should be recorded without their permission, it goes against the resident's rights. The Administrator stated he agreed with the DON.</p> <p>Record review of the facility's policy, titled, Resident Rights, dated 12/01/18, reflected the following:</p> <p>Privacy and Confidentiality</p> <p>You have the right to</p> <p>Privacy, including privacy during visits, phone calls, and while attending to personal needs</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786</p> <p>Based on observation, interview and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, and misappropriation of property for 1 of 6 residents (Resident #1) reviewed for abuse.</p> <ol style="list-style-type: none"> 1. Resident #1 was referred to as a pig and spoken to in a rude manner on a recorded video. 2. Facility staff allowed a visitor to sign in as a volunteer, but was not an approved volunteer. Visitor recorded Resident #1, while at the facility and posted the recording to social media. <p>This deficient practice could cause psychosocial harm due to feelings of embarrassment and loss of dignity.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet, dated 12/06/24, reflected a [AGE] year-old female, who admitted to the facility on [DATE]. Resident #1 had a diagnosis of Mood Disorder (mental illness that affects a person's emotional state), Insomnia (have trouble falling asleep or staying asleep), Essential Hypertension (high blood pressure), and Restlessness and Agitation.</p> <p>Record review of Resident #1's Admission MDS Assessment, dated 10/16/24, reflected Resident #1 had a BIMS score of 05, which indicated Resident #1 was severely impaired.</p> <p>Record review of video #1, posted online on 11/30/24, reflected the Activities Assistant as she spoke to Resident #1 reflected the Activities Assistant as she asked the Visitor Why does she (Resident #1) have so many (cupcakes), did you give her those. The visitor asked, She asked for two, can she not have two?. The Activities Assistant can then be heard telling the visitor, She (Resident #1) will make a pig out of herself so don't. The Visitor and Resident #1 sat at the table together at the time of the conversation.</p> <p>Record review of video #2, posted online on 11/30/24, reflected the Activities Assistant was at one table, and Resident #1 was at a table near the Activities Assistant. The residents were in the dining hall of memory care watching a movie. The Activities Assistant can be heard asking Resident #1, Why don't you go wash your hands?, Resident #1 replied, I am just teasing her (The Visitor), and the Activities Assistant replied to Resident #1, Go wash your hands. Look at the mess you made. An unknown person in the background stated, It's messy, and Activities Assistant can be heard saying, It is. Resident #1 can be seen rolling up the cupcake papers and napkins and stated to the Activities Assistant, I'll go. Resident #1 asked the Activities Assistant, Where can I wash at, and Activities Assistant replied, Try your room, as she starred at Resident #1. Resident #1 replied, Okay, no problem. I messed up. I have to clean up. Resident #1 was observed gathering the crumbs from the cupcake off the table.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/06/24 at 9:45 AM, Resident #1 stated she was having a good morning, as she sat and spoke with other residents in the dining hall of memory care. When Surveyor asked Resident #1 about Thanksgiving, Resident #1 just started Thanksgiving was good. Resident #1 stated the staff were good and she was treated well. Resident #1 did not remember anything specific about Thanksgiving when Surveyor asked.</p> <p>In an interview on 12/06/24 at 11:00 AM, Resident #1's Family Member stated she was very mad and upset when she saw the video on social media. The family member stated she and other family members were upset that someone filmed Resident #1, but they were also upset about how the Activities Assistant spoke to Resident #1. The Family Member stated Resident #1 did not really remember the incident, but she could only remember eating the cupcakes. The Family Member stated she was upset that the Activities Assistant referred to Resident #1 as a pig. The Family Member stated the family contacted the DON and asked for the DON to meet them at the facility. The Family Member stated they sent the videos to the DON, and the DON stated she would have been upset as well. The Family Member stated the DON and Administrator stated the Activities Assistant was going to be suspended.</p> <p>A telephone interview on 12/06/24 at 11:40 AM was attempted to the Activities Assistant, but there was no answer and no returned call.</p> <p>A telephone interview on 12/06/24 at 3:15 PM was attempted to the Visitor, but there was no answer and no returned call.</p> <p>In an interview on 12/06/24 at 3:22 PM, with the Administrator and the DON, the DON stated the facility did not have a policy regarding social media or recording other than for employees. The DON stated Resident #1 did not recall the incident, but Resident #1's family was not happy about how the Activities Assistant spoke to Resident #1. The DON stated they completed safe surveys with all residents. The DON stated they also completed in-services with the staff and the Activities Assistant was in-serviced and suspended at that time. The DON stated the Activities Assistant should not have spoken to Resident #1 in that manner. The DON stated the risk of staff speaking to the residents in that manner was the well-being and feelings of the resident. The Administrator stated he agreed with what the DON stated.</p> <p>Record review of the facility's policy titled, Abuse/Reportable Events, dated 12/01/18, reflected the following:</p> <p>Policy: All residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is everyone's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility.</p> <p>Record review of the facility's policy, titled, Resident Rights, dated 12/01/18, reflected the following:</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Dignity and Respect You have the right to Be treated with dignity, courtesy, consideration, and respect

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786</p> <p>Based on interview and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment were reported immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury to the administrator of the facility and to other officials, including to the State Survey Agency, in accordance with State law through established procedures for one of one resident (Resident #1) reviewed for abuse.</p> <p>The facility failed to report when the Activities Assistant spoke rudely to Resident #1 and called her names on Thanksgiving Day, 11/28/24.</p> <p>This failure could place residents at risk of continued abuse or mistreatment.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 12/06/24, reflected a [AGE] year-old female, who admitted to the facility on [DATE]. Resident #1 had a diagnosis of Mood Disorder (mental illness that affects a person's emotional state), Insomnia (have trouble falling asleep or staying asleep), Essential Hypertension (high blood pressure), and Restlessness and Agitation.</p> <p>Record review of Resident #1's Admission MDS Assessment, dated 10/16/24, reflected Resident #1 had a BIMS score of 05, which indicated Resident #1 was severely impaired.</p> <p>Record review of video #1, posted online on 11/30/24, reflected the Activities Assistant as she spoke to Resident #1 reflected the Activities Assistant as she asked the Visitor Why does she (Resident #1) have so many (cupcakes), did you give her those. The visitor asked, She asked for two, can she not have two?. The Activities Assistant can then be heard telling the visitor, She (Resident #1) will make a pig out of herself so don't. The Visitor and Resident #1 sat at the table together at the time of the conversation.</p> <p>Record review of video #2, posted online on 11/30/24, reflected the Activities Assistant was at one table, and Resident #1 was at a table near the Activities Assistant. The residents were in the dining hall of memory care watching a movie. The Activities Assistant can be heard asking Resident #1, Why don't you go wash your hands?, Resident #1 replied, I am just teasing her (The Visitor), and the Activities Assistant replied to Resident #1, Go wash your hands. Look at the mess you made. An unknown person in the background stated, It's messy, and Activities Assistant can be heard saying, It is. Resident #1 can be seen rolling up the cupcake papers and napkins and stated to the Activities Assistant, I'll go. Resident #1 asked the Activities Assistant, Where can I wash at, and Activities Assistant replied, Try your room, as she starred at Resident #1. Resident #1 replied, Okay, no problem. I messed up. I have to clean up. Resident #1 was observed gathering the crumbs from the cupcake off the table.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/06/24 at 8:55 AM with the DON and the Administrator, The DON stated she became aware of the video and the conversation on the video Thanksgiving weekend. She stated the family of Resident #1 was the one that informed the facility about the video and how the Activities Assistant spoke to Resident #1 on the video. The DON stated the Activities Assistant was suspended pending their investigation. The Administrator stated the incident was not reported to the state. The Administrator did not provide a reason for non-reporting when Surveyor asked.</p> <p>In a follow-up interview with the Administrator and the DON, on 12/06/24 at 12:40 PM, the Administrator stated the risk of not reporting it within 24 hours was the residents' safety. The DON stated safe surveys were completed, as well as in-services on resident rights, abuse/neglect, and customer service.</p> <p>A telephone interview on 12/06/24 at 3:15 PM was attempted to the Visitor, but there was no answer and no returned call.</p> <p>Record review of a document titled, Employee Disciplinary Report, dated 12/04/24, reflected the Activities Assistant was placed on Investigatory Suspension for Activities Assistant depicted on video not providing exceptional customer service to a resident.</p> <p>Record review of the facility's policy titled, Abuse/Reportable Events, dated 12/01/18, reflected the following:</p> <p>Reporting: Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report the allegation to HHSC.</p> <p>If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation</p> <p>If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation.</p>