STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455463	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Meadows Health and Rehabilitation Center	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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that residents, who needed respiratory care, were provided care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of three residents (Resident #1) reviewed for respiratory care. The facility failed to ensure Resident #1's BPAP mask and nasal canula were properly stored in a bag when not in use on 12/30/25. This failure could place the resident at risk for respiratory infection and not having his respiratory needs met.Findings included: Record review of Resident #1's Face Sheet, dated 12/30/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnosis included COPD (shortness of breath). Record review of Resident #1's Quarterly MDS assessment, dated 12/16/25, reflected he had an intact cognitive response. The resident had an active diagnosis of COPD. Record Review of Resident #1's physician orders, dated 12/30/25, reflected BPAP to be worn at night on at HS and off in AM and Oxygen continuously via nasal canula In an observation and interview on 12/30/25 at 8:34 AM, Resident #1 was observed sitting in his wheelchair with his nasal canula from his oxygen concentrator attached to his nose and the nasal canula attached to the oxygen tank connected to the wheelchair was dragging on the floor. The resident's BPAP mask was observed sitting on top of his nightstand unbagged. Resident #1 stated he had not used the mask since 6:00 AM. In an interview and observation on 12/30/25 at 8:36 AM, RN J was shown Resident #1's nasal canula dragging on the floor and his BPAP mask unbagged. He stated he did not know why both items were not bagged. He stated both items should have been bagged to avoid the resident from getting an infection. In an interview on 12/30/25 at 11:24 AM, the DON was told about Resident #1 not having his nasal canula and his BPAP masked bagged. She stated the resident was very non-compliant. She stated it was the nurse's responsibility to ensure both items were bagged. She stated it should be bagged to prevent any cross contamination. In an interview on 12/30/25 at 1:00 PM, the ADON was advised of Resident #1's nasal canula and BPAP mask not being bagged and she stated they should be bagged when not in use to avoid contamination and the resident getting an infection. Review of the facility's policy Oxygen Administration, 10/2020, reflected The purpose of this procedure is to provide guidelines for safe oxygen administration. 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.2. Review the resident's care plan to assess any special needs of the resident.3. Assemble the equipment and supplies as needed.

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
	455463	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Meadows Health and Rehabilitation Center	8383 Meadow Rd Dallas, TX 75231

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents were adequately equipped to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-four of six residents (Resident #2, #3, #4, and #5) reviewed for Resident Call System. The facility failed to ensure the call light system in Resident #2, #3, #4, and #5's rooms were in a position that was accessible to the residents on 12/30/25. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings include: Record review of Resident #2's Face Sheet, dated 12/30/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included reduced mobility and lack of coordination. Record review of Resident #2's Quarterly MDS assessment, dated 12/09/25, reflected a severe cognitive impairment. For ADL care, it reflected the resident required total assistance and an active diagnosis of muscle wasting. Record review of Resident #2's Comprehensive Care Plan, dated 7/07/25, reflected the resident had limited physical mobility and an intervention included encouraging the resident to use the call light for assistance. In an observation on 12/30/25 at 8:38 AM, Resident #2 was observed lying in his bed and his call light was observed hanging from an assist handrail, touching the floor mat on the floor. He was asked if he knew where his call light was located and he stated no. In an interview and observation on 12/30/25 at 8:40 AM, Restorative Aid B showed Resident #2's call light location, and she stated she had just finished bathing the resident and had forgotten to place his call light within his reach. She stated he needed the call light to contact staff if he needed help. Record review of Resident #3's Face Sheet, dated 12/30/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included muscle weakness and lack of coordination. Record review of Resident #3's Quarterly MDS assessment, dated 12/08/25, reflected severe cognitive impairment. For ADL care, it reflected the resident required extensive assistance. Active diagnosis included a stroke. Record review of Resident #3's Comprehensive Care Plan, dated 6/30/25, reflected the resident was a fall risk and one of the interventions was to ensure call light was within reach of the resident. In an observation on 12/30/25 at 8:43 AM, Resident #3 was observed lying in his bed and his call light was observed under his bed on the floor. He was asked if he knew where his call light was located and he stated he did and was pointing to his bed remote. In an interview and observation on 12/30/25 at 8:44 AM, CNA T showed Resident #3's call light location, and she stated someone had just finished bathing the resident and had forgotten to place his call light within his reach. She stated he needed the call light to contact staff if he needed help. Record review of Resident #4's Face Sheet, dated 12/30/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included lack of mobility and unsteadiness on feet. Record review of Resident #4's Quarterly MDS assessment, dated 12/14/25, reflected severe cognitive impairment. For ADL care, it reflected the resident required substantial assistance. Active diagnosis included fractures. Record review of Resident #4's Comprehensive Care Plan, dated 6/30/25, reflected the resident was a fall risk and one of the interventions was to ensure call light was within reach of the resident. In an observation on 12/30/25 at 8:46 AM, Resident #4 was observed lying in her bed. She was asked if she knew where her call light was located and she stated it was on her bed, but the call light was observed on the floor, on the far side of the nightstand. In an interview and observation on 12/30/25 at 8:47 AM, CNA T was shown Resident 4's call light location, and she stated she did not know why the resident's call light was not within her reach. She stated she was not the CNA for the resident. She stated the resident needed the call light within reach to contact staff if she needed help. Record review of Resident #5's Face Sheet, dated 12/30/25, reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included lack of mobility and unsteadiness on feet. Record review of Resident #5's Quarterly MDS assessment, dated 12/29/25, reflected severe cognitive impairment. For ADL care, it reflected the resident required substantial assistance. Active diagnosis included a lack of coordination. Record review of Resident #4's Comprehensive Care Plan, dated 6/27/25, reflected the resident was a fall risk and one of the interventions was to ensure call light was within reach of the resident. In an observation on 12/30/25 at 8:50 AM, Resident #5 was observed lying in her bed and her call light was observed on the floor, near the back wall. In an interview and observation on 12/30/25 at 8:52 AM, LVN N was shown Resident #5's call light location, and he stated he did not know why the call light was not within reach of the resident. He stated it was the nurses and CNAs responsibility to ensure the