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	01/07/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source were reported immediately, but no less than two hours after the allegation was made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation did not involve abuse or did not result in bodily injury, to the facility administrator and to other officials in accordance with State law through established procedures for one (Resident #1) of four residents reviewed for abuse. The facility failed to report an allegation of abuse towards Resident #1 when reported by a staff member. This failure could place residents at risk for delayed investigation, intervention and abuse.Findings included: Record review of Resident #1's face sheet, dated 01/07/26, reflected he was an [AGE] year-old male, admitted on [DATE]. Resident #1's diagnoses included metabolic encephalopathy (a brain dysfunction caused by systemic metabolic disturbances, leading to symptoms like confusion, memory loss and altered consciousness), vascular dementia (a type of dementia caused by reduced blood flow to the brain, leading to cognitive decline and memory issues), diabetes (a chronic condition where the body can't effectively use or produce insulin, leading to high blood sugar), schizophrenia disorder (a chronic brain disorder causing symptoms like hallucinations, delusions, disorganized thinking and reduced emotional expression), schizoaffective disorder (a serious mental illness blending symptoms of schizophrenia hallucinations, delusions with a mood disorder), and insomnia (difficulty sleeping). Record review of Resident #1's quarterly MDS assessment, dated 10/29/25, reflected a BIMS score of 06 which indicated severe cognitive impairment. Resident #1 had no signs or symptoms of delirium, no negative mood problems identified and no verbal or physical behaviors directed towards others. Resident #1 had range of motion impairment on both sides of his lower extremities and used a walker as a mobility device. He required moderate/partial assistance for all ADLs and was frequently incontinent of bowel and bladder. Resident #1 received high-risk medications which included antipsychotic, antidepressant, and hypoglycemic medication. Record review of Resident #1's current care plan, initiated 12/29/25, reflected no identified behaviors and no use of psychotropic medications. The current care plan did not discuss the acute behavioral incident on 12/24/25 and 12/31/25 and the new orders obtained for PRN medication. The previous care plan initiated in December 2024 (separate document) reflected Resident #1 took antipsychotic medication, had a diagnosis of vascular dementia and schizophrenia and required psychotropic medication for insomnia. The previous care plan did not indicate any identified behavioral issues or psychological concerns. Record review of Resident #1's psychiatric follow-up evaluation dated 12/17/25 by Psyche NP B, reflected Resident #1 was seen for medication monitoring and management of psychotropic medications following reports of irritability, restlessness and need for redirection and cues from staff. The evaluation reflected Resident #1 was observed eating lunch in the dining (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	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** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's rights, that included measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that were identified in the comprehensive assessment for one (Resident #1) of four residents reviewed for care plans. The facility failed to develop and implement a care plan for Resident #1 that was individualized to his care needs, which included psychotropic medications, dementia and related behaviors, and acute use of PRN antipsychotic medication after a behavioral incident. This failure could place residents at risk for inappropriate responses to behavioral symptoms and inappropriate use of psychotropic medications.Findings included: Record review of Resident #1's face sheet, dated 01/07/26, reflected he was an [AGE] year-old male, admitted on [DATE]. Resident #1's diagnoses included metabolic encephalopathy (a brain dysfunction caused by systemic metabolic disturbances, leading to symptoms like confusion, memory loss and altered consciousness), vascular dementia (a type of dementia caused by reduced blood flow to the brain, leading to cognitive decline and memory issues), diabetes (a chronic condition where the body can't effectively use or produce insulin, leading to high blood sugar), schizophrenia disorder (a chronic brain disorder causing symptoms like hallucinations, delusions, disorganized thinking and reduced emotional expression), schizoaffective disorder (a serious mental illness blending symptoms of schizophrenia hallucinations, delusions with a mood disorder), and insomnia (difficulty sleeping). Record review of Resident #1's quarterly MDS assessment, dated 10/29/25, reflected a BIMS score of 06 which indicated severe cognitive impairment. Resident #1 had no signs or symptoms of delirium, no negative mood problems identified, and no verbal or physical behaviors directed towards others. Resident #1 had range of motion impairment on both sides of his lower extremities and used a walker as a mobility device. He required moderate/partial assistance for all ADLs and was frequently incontinent of bowel and bladder. Resident #1 received high-risk medications which included antipsychotic, antidepressant and hypoglycemic medication. Record review of Resident #1's current care plan, initiated 12/29/25, reflected no identified behaviors and no use of psychotropic medications. The current care plan did not discuss the acute behavioral incident on 12/24/25 and 12/31/25 and the new orders obtained for PRN medication. The previous care plan initiated in December 2024 (separate document) reflected Resident #1 took antipsychotic medication, had a diagnosis of vascular dementia and schizophrenia and required psychotropic medication for insomnia. The previous care plan did not indicate any identified behavioral issues or psychological concerns. Record review of Resident #1's physician order summary printed 01/06/25 reflected Resident #1 was prescribed the following medications: Haloperidol Lactate Injection Solution 5ml intramuscularly once time only related to restlessness and agitation for one date (Start Date: 12/30/25 4:15 PM), Xanax Oral Tablet 0.5mg give once every six hours as needed for restlessness and agitation for 14 days (Start Date 12/24/25 at 10:00 PM), Mirtazapine 7.5 mg once at bedtime for insomnia (antidepressant, start date 09/23/25), Seroquel Oral Tablet 200 mg two times a day for vascular dementia without behavioral disturbance (start date 12/03/25), Trazadone 50 mg give 0.5 tablet by mouth three times a day for depression (start date 10/01/25) and Depakote Sprinkles 125mg- give four capsules by mouth two times a day related to vascular dementia (Start date 10/23/25). Review of Resident #1's December 2025 MAR reflected he was administered prn Xanax on 12/28/25 at 8:03 a.m. The MAR also reflected he was administered prn IM Haldol on 12/31/25 at 7:20 a.m. An interview with LVN H on 01/07/26 1:17 p.m. revealed she was the MDS nurse and she was responsible for care planning residents prescribed (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychotropic medications. LVN H stated around November 2025 the facility underwent a change of ownership. At that time, the existing care plans did not transfer to the new online system. As a result, all the residents' care plans had to be recreated. LVN H said rebuilding the care plans for a large number of residents while also managing MDS responsibilities was challenging as she was the only person doing it. She stated care plan conferences continued to occur with interdisciplinary participation, but individualized care plans required extensive reconstruction. LVN H stated Resident #1 was on her list, however, during this care plan transition time frame, she had not updated his yet. LVN H was uncertain if she was the only person who could update care plans for acute and new issues. She stated licensed nurses should be capable of initiating care plan updates as well as when clinically significant changes occurred. LVN H stated the importance of individualized behavior-based care planning for residents with dementia and psychotropic medication use and stated the care plans should include specific behaviors, triggers and interventions to guide nursing care. Review of the facility's policy titled, Comprehensive Person-Centered Care Plans, revised March 2022 reflected, .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.10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers; 11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs for one (Resident #1) of four residents who were reviewed for psychotropic medications. The facility failed to ensure Resident #1, who had a diagnosis of dementia, was administered PRN Haldol (antipsychotic) with adequate indications for its use. The facility nurse administered PRN Haldol intramuscularly when Resident #1 refused ADL care and was combative. This failure could place residents at risk for being administered unnecessary antipsychotic medication to control behaviors and could have adverse side effects including over-sedation, confusion and decreased quality of life.Findings included: Record review of Resident #1's face sheet, dated 01/07/26, reflected he was an [AGE] year old male, admitted on [DATE]. Resident #1's diagnoses included metabolic encephalopathy (a brain dysfunction caused by systemic metabolic disturbances, leading to symptoms like confusion, memory loss and altered consciousness), vascular dementia (a type of dementia caused by reduced blood flow to the brain, leading to cognitive decline and memory issues), diabetes (a chronic condition where the body can't effectively use or produce insulin, leading to high blood sugar), schizophrenia disorder (a chronic brain disorder causing symptoms like hallucinations, delusions, disorganized thinking and reduced emotional expression), schizoaffective disorder (a serious mental illness blending symptoms of schizophrenia hallucinations, delusions with a mood disorder), and insomnia (difficulty sleeping). Record review of Resident #1's quarterly MDS assessment, dated 10/29/25, reflected a BIMS score of 06 which indicated severe cognitive impairment. Resident #1 had no signs or symptoms of delirium, no negative mood problems identified and no verbal or physical behaviors directed towards others. Resident #1 had range of motion impairment on both sides of his lower extremities and used a walker as a mobility device. He required moderate/partial assistance for all ADLs and was frequently incontinent of bowel and bladder. Resident #1 received high-risk medications which included antipsychotic, antidepressant, and hypoglycemic medication. Record review of Resident #1's current care plan, initiated 12/29/25, reflected no identified behaviors and no use of psychotropic medications. The current care plan did not discuss the acute behavioral incident on 12/24/25 and 12/31/25 and the new orders obtained for PRN medication. Record review of Resident #1's previous care plan initiated in December 2024 reflected Resident #1 took antipsychotic medication, had a diagnosis of vascular dementia and schizophrenia and required psychotropic medication for insomnia. The previous care plan did not indicate any identified behavioral issues or psychological concerns. Record review of Resident #1's psychiatric follow-up evaluation, dated 12/17/25, by Psyche NP B, reflected the resident was seen for medication monitoring and management of psychotropic medications following reports of irritability, restlessness and need for redirection and cues from staff. The evaluation reflected Resident #1 was observed eating lunch in the dining room, appeared calm, and was in no apparent physical or emotional distress at the time of the observation. Psyche NP B documented Resident #1 had dementia and insomnia with cognitive impairment. Chart review by Psyche NP B noted no supporting evidence to validate diagnosis of schizophrenia or schizoaffective disorder and Psyche NP B documented those diagnoses should be removed from Resident #1's medical record due to lack of evidence. Resident #1's current psychotropic medications were reflected as Seroquel (for agitation), Depakote sprinkles (for mood disorder), Trazadone (for agitation and dementia) and Remeron (for insomnia). Record review of Resident #1's physician order summary dated 01/06/25 reflected Resident #1 was prescribed the following medications: Haloperidol Lactate Injection Solution 5ml intramuscularly once time only related to restlessness and agitation for one date (Start Date: 12/30/25 4:15 PM), Xanax Oral Tablet 0.5mg give once every six hours as (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed for restlessness and agitation for 14 days (Start Date 12/24/25 at 10:00 PM), Mirtazapine 7.5 mg once at bedtime for insomnia (antidepressant, start date 09/23/25), Seroquel Oral Tablet 200 mg two times a day for vascular dementia without behavioral disturbance (start date 12/03/25), Trazadone 50 mg give 0.5 tablet by mouth three times a day for depression (start date 10/01/25) and Depakote Sprinkles 125mg- give four capsules by mouth two times a day related to vascular dementia (Start date 10/23/25). Review of Resident #1's December 2025 MAR reflected he was administered prn Xanax on 12/28/25 at 8:03 a.m The MAR also reflected he was administered prn IM Haldol on 12/31/25 at 7:20 a.m. The MAR did not reflect any behaviors occurring at the time of prn administration under the behavior monitoring section. Record review of nursing progress notes for Resident #1 reflected:-12/17/25 at 3:05 p.m.by LVN A, Resident noted with more jumpy behavior and combative during care and continues to have an outburst episodes, yelling mama, mama, and trying to kick staff, pt requires more cues to eat, redirected and educated multiple times but not effective, Pt vital signs WNL BP-106/66, P-63, R-18, T-97.7, Spo2- 97% RA, behavior reported to Psych NP. No new order.-12/24/25 at 9:05 p.m.by LVN A, Resident continues with outburst and aggressive behavior, yelling mama, mama, and trying to kick staff, pt redirected and educated several times but not effective, was reported to NP psych N/O received Xanax 0.5 mg PO every 6 hrs. PRN x 14 days r/t restlessness and agitation. Resident and family notified. MAR updated.-12/30/25 at 8:25 a.m. by LVN A, Late Entry: Note Text: Writer obtained order for prn Haldol IM inj, all orders carried. Will continue to update chart prn.-12/30/25 at 3:06 p.m.by LVN A, Resident continues with outburst and aggressive behavior, yelling mama, mama, and trying to kick staff, when brought to the dining area this AM resident started knocking down the chair and the tables, when redirecting, resident become more restless and agitated, hitting, scratching and kicking the staff members including this writer, he was quickly move out from the dining area and brought back to his room, this writer stayed with him notified DON, ADON and MD, N/O order obtained Haloperidol 5mg/ml Inject1ml intramuscularly one time only as needed. MAR updated, resident and family informed.-12/30/25 at 3:09 p.m. by LVN A, Xanax 0.5 mg 1 tab PO was administered but not effective. An interview with CNA B on 01/06/25 at 1:22 p.m. revealed she worked in the secured unit on the morning shift, took care of Resident #1 for about a year and was very familiar with his behaviors and care needs. CNA B stated on the morning of 12/24/25, she was the CNA responsible for Resident #1. She said that morning, Resident #1 had stool in his brief and needed to be changed. She stated sometimes he did not want care, and when that happened, she went to the charge nurse for assistance. On that morning (12/24/25), CNA B said she notified LVN A of Resident #1's resistance to ADL care. LVN A came to assist with care and they placed Resident #1 in his wheelchair and took him to the dining room. She stated while in the dining room, Resident #1 began knocking on the table and making noise. She stated that behavior happened once in a while but not every day. CNA B stated because of the noise and the reactions of the other residents, she and LVN A decided to remove Resident #1 from the dining room to prevent further problems. She stated Resident #1 was taken back to his room and placed in bed so he would calm down and would not start pulling at other residents. She stated Resident #1 did not slap or hit any other residents during the dining room incident. CNA B stated if a resident hit staff, staff were not supposed to do anything back. She stated the usual response was to remove the resident from the situation and give them time to calm down. She stated that sometimes nursing staff administered medication to calm Resident #1 when he got agitated. CNA B stated that after time in his room, Resident #1 typically calmed down. CNA B stated after the incident on 12/24/25, she did not observe any bruises or injuries on Resident #1 when showering or providing care. An interview with LVN A on 01/06/25 at 2:13 p.m. revealed she was the charge nurse on the secured unit. LVN A (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated on 12/24/25, CNA B reported Resident #1 was being kind of resistant. He had a bowel movement and CNA B was trying to provide incontinent care. LVN A said she did not observe Resident #1 being resistant, but CNA B told her that he refused to let her turn him to provide incontinent care. LVN A stated, You know, she [CNA B] asked him to roll over, but he didn't want to, he wanted to stay on his back. LVN A said when she went to his room, she talked to him and said please and Resident #1 was compliant, so they got him dressed and took him to the dining room. Once in the dining room, Resident #1 was sat at a table where nobody else sat and started screaming mama mama! LVN A said Resident #1 knocked down a table and pushed a chair, so for the safety of the other residents, he was taken back to his room by herself and CNA B. LVN A stated she did not touch Resident #1 in the dining room and although he was trying to stand up, he sat back down on his own. She said Resident #1 hit her on the nose while trying to remove him from the dining room. When she got him back to his room, LVN A stated she asked Resident #1 if he was okay and he said no and kept repeating mama, mama, mama, mama. LVN A stated she then transferred him back to bed with CNA B, contacted the doctor, ADON G, and stayed with him until he calmed down. LVN A said Resident #1 calmed down through her talking to him. She said once he was calm, she administered him a PRN Xanax. LVN A stated, He was not really calmed down, but not like aggressive as before. So, I gave it to him to calm down. She said Resident #1 then ate his breakfast and went to eat lunch in the dining room later and was quiet in his demeanor. LVN A stated a couple of days later (date unknown-morning), Resident #1 was destructive and combative. She said CNA B went to get him up and he was tried to fight with her, so LVN A went to see what was going on. She stated Resident #1 was kicking at the air from his bed towards CNA B and herself. LVN A said he was combative and tried to kick her when she approached him. LVN A stated, So I said because I have an order for it (Haldol), well let me give it to him. She said he calmed down after the intramuscular medication administration. LVN A stated Haldol was a one-time only medication and not ongoing. She said she already had the order for the Haldol from the day before. LVN A stated she did not give Resident #1 PRN Xanax during the behavioral incident in his room because he spit it out and that was why she administered PRN Haldol. LVN A stated she knew when it was time for a resident to be administered a PRN psychotropic medication, When the outburst becomes prolonged and you become combative. That's then it's time to administer. An interview with C-RN F on 01/07/26 at 10:30 a.m. revealed PRN IM Haldol would be appropriate for use when a resident had uncontrollable behaviors or behaviors that endangered other residents. She stated she did not know what behaviors occurred with Resident #1 that led to PRN Haldol administration. C-RN F stated there were some acknowledged errors in facility documentation, including no psychotropic medications listed on the care plan, no behaviors documented and behavior monitoring logs reflecting zeros despite medication administration for Resident #1. She stated IM antipsychotics should not be used to compel residents to get out of bed or comply with care. She stated monitoring following antipsychotic administration should occur for three days, including mood, appetite and behavior monitoring, with inclusion on the 24-hour report and emphasized that incomplete documentation undermined care delivery and regulatory compliance. She reported that an in-service on documentation was conducted with the nursing staff for those areas since the incident occurred. Interview with the ADM on 01/07/26 at 1:30 p.m. revealed IM antipsychotics such as Haldol should be used only when a resident posed a threat to themselves or others. He stated he would expect less restrictive interventions to be attempted first and then would review whether oral PRNs such as Xanax were effective. He stated that resisting care alone would not justify IM antipsychotic use and that staff should step away and return later. The ADM stated residents had the right to refuse care. For residents with dementia, he stated situations may be more complex but still (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emphasized encouragement, stepping away and physician involvement rather than immediate medication escalation. The ADM stated that oversight of PRN antipsychotic use would occur through review of orders and discussions during stand-up meetings with the management team. He stated the DON or the designee would typically review any decisions on psyche PRN use. An observation and interview with Resident #1 was attempted on 01/07/26 at 1:46 p.m. and revealed he did not eat his lunch and his full plate of food was in front of him on the table. His eyes were closed and he was slightly slumped over in his wheelchair. A CNA tried to rouse him and he then jerked his body a few times in waking up and began slowly eating. Resident #1 was not responsive to questions and kept his eyes closed, including through eating his food. He was observed to be in a wheelchair, elderly and not able to particulate in an interview. He was not observed to have any visible injuries on his face, hands or arms at the time of the observation. An interview with CNA E on 01/07/26 at 1:55 p.m. revealed Resident #1 was not normally aggressive and stated repeatedly, That man is not aggressive. She stated that she had worked with Resident #1 regularly since beginning her employment at the facility three weeks prior and had not observed him engaging in violent or combative behaviors. She stated that when she assisted Resident #1 with care, she was typically able to get him up, talked to him and redirected him without difficulty. On the morning of the incident (12/24/25), CNA E stated she first became concerned when she heard commotion and distress sounds coming from the dining room area. She described hearing loud voices and raised tones and stated the situation didn't feel right. She stated she observed Resident #1 being brought into the dining room and he appeared upset, confused, was attempting to communicate but struggling to express himself clearly. She recalled him repeating fragments such as feel, feel, feel. CNA E stated she was able to calm Resident #1 by speaking softly and reassuring him, telling him, [NAME], it's me. She emphasized that this approach worked and helped him de-escalate. In contrast, she described the other staff, specifically CNA B and LVN A using loud, commanding voices and repeatedly telling Resident #1 to sit down, sit down! which she felt escalated the situation. She stated, Y'all didn't give him time, and explained residents had the right to be mad and had the right to be left alone for a little while. She stated staff kept giving him commands rather than allowing him time to calm down. CNA E stated after the dining room incident, Resident #1 was taken back to his room. She stated she never saw Resident #1 flip tables or chairs and stated while he may have pushed against furniture, he did not have the physical strength to seriously harm others. She stated she did not see him assault other residents and did not believe he posed the danger later described by staff. Review of the facility's policy titled, Antipsychotic Medication Use, revised July 2022 reflected, Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. 9. Diagnoses alone do not warrant the use of antipsychotic medication. In addition to the above criteria, antipsychotic medications will generally only be considered if the following conditions are also met: a. The behavioral symptoms present a danger to the resident or others; AND: (1) the symptoms are identified as being due to mania or psychosis (such as auditory, visual, or other hallucinations; delusions, paranoia or grandiosity); or (2) behavioral interventions have been attempted and included in the plan of care, except in an emergency. 12. Antipsychotic medications will not be used if the only symptoms are one or more of the following: .c. Restlessness; . k. Uncooperativeness; 13. Residents will not receive PRN doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record.