

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 01/15/2025
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971</p> <p>Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 2 (Resident #30 and Resident #48) of 8 residents reviewed for ADLs.</p> <p>The facility failed to ensure:</p> <ul style="list-style-type: none"> - Resident #30 had his fingernails cleaned and trimmed. - Resident #48 had his fingernails cleaned and trimmed. <p>These failures could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life.</p> <p>Findings include:</p> <p>Resident #48</p> <p>Record review of Resident #48's Quarterly MDS assessment dated [DATE] reflected Resident #48 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included cerebral infarction (a condition that occurs when blood flow to the brain is blocked. The blockage can lead to brain tissue death), muscle weakness, and need for assistance with personal care. Resident #48's BIMS score of 15, which indicated Resident #48 was cognitively intact. The MDS assessment indicated Resident #48 required moderate assistance with personal hygiene.</p> <p>Record review of Resident #48's Care Plan dated 12/11/24, reflected the following: Problem: Resident requires assistance with all ADL functions . Goal: will maintain a sense of dignity by being clean, dry, odor free and well groomed . Approach: . assist with ADLs PRN .keep fingernails cut to prevent self-scratching .</p> <p>In an observation on 01/13/25 at 9:36 AM revealed Resident #48 was laying in his bed. The nails on both hands were approximately 0.4cm in length extending from the tip of his fingers. Resident #48 stated he did not like his fingernails long because it would bleed when scratching. He stated he did not tell anybody about his fingernails because they were busy.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 01/13/25 at 3:24 PM, CNA L stated CNAs were allowed to cut the residents' nails if they were not diabetic. CNA L stated she did not see Resident #48's nails when she did her round. She stated she would do it right then. She stated the risk would be infection control and injury.</p> <p>Resident #30</p> <p>Record review of Resident #30's Quarterly MDS assessment dated [DATE] reflected Resident #30 was a [AGE] year-old male admitted to the facility on [DATE] with a readmission on 03/02/2024 with diagnoses included cerebral infarction (a condition that occurs when blood flow to the brain is blocked. The blockage can lead to brain tissue death) affection left side, muscle wasting, hemiplegia (a condition that causes weakness or paralysis on one side of the body) and need for assistance with personal care. Resident #30 was unable to complete the interview for mental status (BIMS), the assessment reflected Resident #30 was cognitively moderately impaired. The MDS assessment indicated Resident #30 was dependent with personal hygiene.</p> <p>Record review of Resident #30's Care Plan revised 01/02/25, reflected the following: Problem: Resident has an ADL self-care performance deficit and has limited physical mobility related to cerebral infarction . Goal: Resident will maintain current level of . personal hygiene . Approach: . Check nail length and trim and clean as necessary .</p> <p>In an observation on 01/13/25 at 10:20 AM revealed Resident #30 was laying in his bed. The nails on both hands were approximately 0.4 cm in length extending from the tip of his fingers. The nails were discolored tan and had dark brown colored residue underside and on the nails' bed. Resident #30 was unable to answer questions.</p> <p>In an interview on 01/13/25 at 3:08 PM, LVN K stated nurses and CNAs were responsible to clean and cut residents' nails. LVN K stated she always cut Resident #30's nails because of his contraction . Splint was in place; fingernails were not digging in the resident's skin. LVN K stated she did not check his nails today. She told resident, she would come back to clean and cut his nails. She stated the risk would be resident's dignity and skin breakdown. Observation on 01/14/25 at 10:05 AM revealed Resident #30's nails on both hands were clean and trimmed.</p> <p>In an Interview on 01/14/25 at 12:02 PM, the DON stated nail care should be completed as needed and every time aides wash the residents' hands. The DON stated nails should be observed daily. The DON stated nurses were responsible for trimming the nails of residents who were diabetic, and CNAs could trim other residents' nails. The DON stated she expected CNAs to offer to cut and clean nails if they were long and dirty. The DON stated the ADON and the DON would do the routine rounds to monitor. The DON stated residents having long and dirty could be an infection control issue.</p> <p>Record review of the facility's policy Activities of Daily Living dated December 2018, reflected the following: . It is the policy of this home to assure residents have their activities of daily living met .</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for two (Residents #3 and #12) of seven residents reviewed for range of motion.</p> <p>The facility failed to implement interventions to prevent further decline of Resident #3's and Resident #12's contracture to her left hand upon discharge from therapy services.</p> <p>These failures could place residents at risk for decline in range of motion, decreased mobility, and worsening of contractures.</p> <p>Findings included:</p> <p>Resident #3</p> <p>Review of Resident #3's Face sheet dated 1/15/25 reflected a [AGE] year-old female with an admitted [DATE].</p> <p>Review of Resident #3's quarterly MDS assessment, dated 10/12/24, reflected she was severely cognitively impaired with a BIMs of 00. The resident had upper and lower extremity impairment on one side. Resident #3 was started on OT on 9/25/24. Active diagnoses included Seizure Disorder (uncontrolled jerking, loss of consciousness, or other symptoms caused by abnormal electrical activity in the brain), Hemiplegia and Hemiparesis (muscle weakness or partial paralysis on one side of the body) and Other Cerebrovascular disease (can include brain aneurysms, brain bleeds, carotid artery disease and transient ischemic attacks or mini strokes)</p> <p>Review of Resident #3's physician orders on 1/14/25 revealed no orders for contracture management.</p> <p>Review of Resident #3's Physician Order Report dated 1/8/2025-1/15/2025 revealed Order dated 1/15/25 Contracture Management: May wear L Resting splint as tolerated to decrease risk of contractures. Twice A Day; 06:00 - 14:00, 14:00 - 22:00 (6:00am - 2:00pm, 2:00pm to 10:00pm) Order dated 1/14/2025 PT/OT/ST to eval and treat if indicated .</p> <p>Review of Resident #3's comprehensive care plan revised on 10/10/24, reflected, 10/23/24 reflected . Problem Start Date: 04/13/2022 Category: ADLs Functional Status/Rehabilitation Potential The resident has an ADL Self Care Performance Deficit and has limited physical mobility r/t history or cerebral infarction with hemiplegia, rheumatoid arthritis, and dementia Edited: 10/23/2024 . Approach Start Date: 04/13/2022 Approach End Date: 01/23/2025 The resident has contractures of the hands, feet. Provide skin care to keep clean and prevent skin breakdown. Edited: 10/23/2024 . Resident #3 has Contractures to BUE and BLE and is at risk for skin break down, increased pain from affected areas and injury . Approach Start Date: 05/12/2021 Approach End Date: 01/23/2025 Therapy referral as needed Edited: 10/23/2024 .</p> <p>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #3's OT Discharge summary dated 11/5/24 revealed Skilled Intervention . Orthotic management and training initial Skin checked prior to application of splint with not redness, irritation or breakdown noted .</p> <p>An observation and interview of Resident #3 on 01/13/25 at 11:40am revealed Resident had left contracted hand and stated they are not doing anything about her hands or legs.</p> <p>An observation and interview of Resident #3 on 1/14/25 at 10:42am in her room. She had no splint on either hand or stated that they will not help her. She stated the facility only does minimum and would like to leave the facility because they do not help.</p> <p>An interview with RN D on 1/14/25 at 4:09pm revealed Resident #3 had contracture on her knee however RN D stated she had not noticed contractures on either hand. She did not think she had Resident #3 down for a splint but would check. She stated that monitoring for decline of Resident #3 mobility was continuous and the same for every patient.</p> <p>An observation of Resident #3 on 1/15/24 at 8:49am in resident's room and she was asleep in her bed. She had no splint to either hand.</p> <p>An interview with CNA H on 1/15/24 at 9:15am revealed Resident #3 would resist care and would tell people to get out. Resident could move herself on her bed. Resident had a strong dominant side and could pull up but only when she wanted to. Resident could move both her hands. CNA H stated Resident #3 had a splint or had one a long time ago. CNA H stated if she thought there was an issue with a new contracture, she would tell the nurse and the rehab director.</p> <p>An interview with DOR on 1/14/25 at 3:15pm revealed that residents are initially assessed for OT, PT and speech. They typically received a verbal referral or written referral from the nurses. He stated Resident #3's last evaluation for PT was on 11/12/24 and discharged [DATE]. She was discharged due to plateauing, meaning she had reached her highest potential in therapy. She received PT for range of motion, endurance, flexibility, and strength to improve ADLs. Resident #3 had OT on 9/25/24 for contractor management and positioning. She was discharged from OT on 11/05/24 due to plateauing on some of her range of motion goals. The contracture was on the left side. He stated there was an order for splint on 11/5/24. If a resident had a significant change in condition the nurse would refer her back to therapy. The risk to the resident for not using the splint would be decrease range of motion and increase in contracture.</p> <p>Resident #12</p> <p>Record review of Resident #12's quarterly MDS assessment dated , 12/11/24/23 reflected Resident #12 was a [AGE] year-old male admitted to the facility on [DATE]. Resident #12 had diagnoses of Diabetes mellitus (high blood glucose), hypertension, Cerebrovascular accident (blood flow to the brain is cut off), hemiplegia(paralysis of one side of the brain) following cerebral infarction (stroke) affecting left non-dominant side, aphasia, Depression, Muscle weakness (generalized). Resident #12 had a BIMS Score of 9 indicated moderate cognitive impairment. Resident #12 had moderate assistance for Showering and Upper body dressing.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #12's Comprehensive Care Plan, dated revised 01/14/25 , reflected, Problem: [Resident #12] has Contractures to L [Left] hand and is at risk for skin break down, increased pain from affected areas and injury. Long Term Goal: Contractures will not increase, skin break down will not occur, increased pain will be relieved within one hour of intervention and no injuries will occur over next 90 days. Approach: Contracture Management: May wear L [Left] Resting splint as tolerated to decrease risk of contractures.</p> <p>Record review of Resident #12 physician order dated 1/14/25 reflected, Contracture Management: May wear L Resting splint as tolerated to decrease risk of contractures. Twice A Day; 06:00 AM - 2:00 PM and 2:00 PM - 10 PM.</p> <p>In an observation on 01/13/25 10:19 AM revealed Resident #12 was sitting in the hallway in a chair. He had a contracture on his left hand and did not have a splint.</p> <p>In an observation on 01/14/25 09:38 AM revealed Resident #12 with contractures and no splint on his left hand. Resident #12 was grimacing and held his left wrist with his right hand. Resident was aphasic and answered yes or no questions. Resident nodded no when asked if he could open his left hand. Resident also nodded No when asked if he wore a splint.</p> <p>In an interview on 1/14/25 at 9:56 AM, LVN C stated she did not know if Resident #12 had a splint for his contractures on left hand. She stated that she was aware he had contractures but did not know if Resident #12 had OT therapy. She stated that she had not splint on his hand for the last 3-4 months since she worked at the facility.</p> <p>In an observation and Interview on 01/14/25 12:21 PM of Resident#12's left hand, revealed that Resident #12 had splint on his left hand. Resident #12 nodded yes to therapy providing him with the splint.</p> <p>In an interview on 01/14/25 02:11 PM, the DOR revealed Resident #12 was on OT therapy twice during his stay at the facility for contracture management. He stated Resident #12 was discharged from Occupational Therapy on 12/2/24 due to plateauing on some of her range of motion goals. The DOR revealed after the resident was discharged , it was up to the nurses to continue with the splint order. The DOR revealed the splint was used to protect contractures getting worse, getting indication on the skin and pain as well as increased need for help with ADLs.</p> <p>In a phone interview on 01/14/25 at 02:39 PM with COTA G revealed Resident #12 had contractures on left hand since admission to the facility. He stated that a splint was provided for his contractures that Resident #12 could wear for 3-4 hours per his comfort level. He stated he was called By LVN C in the morning of 1/14/25 and asked about Resident #12 splint. He stated Resident #12's splint was in the drawers in Resident #12's room and had clothes on top of it.</p> <p>An interview with DON on 1/15/25 10:07am revealed that the facility handled patients who needed splints for contractures by reviewing recommendations with rehab for the splint. Then during standup meetings the resident's need for splint would be discussed. The orders for a splint would be in the system for all staff to be able to see it. The risk of not following recommendation from rehab on the split for contracture, was that the contractures could increase, and the residents could have an increased need for help with ADLs.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with Administrator on 1/15/25 10:30am revealed that his expectations for managing contractors were for care staff to note them, then notify DON and DON would make referral to rehab. His expectation was that therapy would provide any recommendations to the DON and possibly an order for any recommendations such as splints. Recommendation from rehab were given through the 24-hour report and should be in the Care Plan. MDS would make any updates within 72 hours. If all care staff were unaware of a need, such as a splint for a contracture, it could cause further decline for the resident.</p> <p>Record review of the facility's Range of Motion Exercises policy, dated December 2018, reflected: It is the policy of this home to provide range of motion for residents in order .7. To prevent contractures from becoming worse if they are already present</p> <p>50910</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560</p> <p>Based on observation and interview, and record review, the facility failed to maintain an environment as free of accident hazards as is possible for one of two shower rooms (shower room [ROOM NUMBER]) in the facility's secured unit, reviewed for accidents and hazards.</p> <p>The facility failed to ensure shower room [ROOM NUMBER] was locked.</p> <p>These failures could place residents at risk of accidents, injury, or consuming hazardous personal care products.</p> <p>Findings included:</p> <p>An observation of the secured unit on 01/13/25 10:55 AM revealed Shower room [ROOM NUMBER] was unlocked when not in use.</p> <p>An observation of the secured unit on 01/13/25 03:07 PM revealed Shower room [ROOM NUMBER] was unlocked. A cabinet in the shower room was unlocked with the unpadlocked hanging on the door. The cabinet contained multiple bottles of Shampoo, body cleanser, body lotion, and an opened twin [NAME] razor box. The shower area of the shower room had a cleanser that was kept by itself on a table.</p> <p>In an interview on 1/13/25 at 3:20 PM, CNA F stated he had worked at the facility for about 3 years. He stated that the shower room in the secured unit should always be kept locked when not in use. He stated that residents in the secured unit wandered in and out of rooms and shower room door should be locked to ensure the safety of the residents in the secured unit. He said the charge nurse had the keys to the door, but he was not sure about the cabinet lock key inside the shower room. He said residents could get into personal care products and ingest them accidentally or dispense them on the floor which may result in falls.</p> <p>In an observation and interview on 01/14/25 09:14 AM with LVN C revealed She said Shower room [ROOM NUMBER]'s door should be locked to ensure the safety of residents. She said personal care items should be secured in the cabinet in the shower room and locked. She said some of the residents in the secured unit were confused and the unlocked door and cabinet posed a risk of accidents to the residents. She stated she had the keys to the shower room but was not certain she had keys to the cabinet lock inside the shower room. She stated she worked in the facility from past 5-6 months and could not remember about received an Inservice from the facility regarding locking shower or storage rooms in the secured unit, however she knew the doors needed to be locked form her nursing background. She stated the risk were exposed to a fall and accident with unlocked shower doors that had personal care items and sharp objects such as razors.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 01/15/25 11:30 AM, the DON stated her expectation was the shower room in the secured unit was locked when not in use. She said the doors needed to be secured to ensure the safety of the residents and minimize any possibility of accident or hazard. She stated that residents in the secured unit had low BIMS and were at risk of ingesting personal care items or falls. She said the facility did not have a policy directing accident and hazards but expected all staff to ensure resident safety. She stated that it was her responsibility as a DON to train staff members regarding safety practices in a secured unit, however, could not remember when the last in service was conducted. She stated as a DON, she or her designee conducted daily rounds in all units to ascertain quality of care for the residents. She also stated the charge nurses retain keys to the shower room and the cabinet lock inside the cabinet lock inside the shower room. She stated there was no facility policy directing accident and hazards in a secured unit.</p> <p>In an interview on 01/15/25 12:23 PM, the Administrator stated he recognized the importance of the doors being locked as there were items in both the shower room and the storage rooms that could pose a risk of harm to residents. He said the facility did not have a policy related to accidents or hazards. He added the DON was responsible for ascertaining training is provided to staff members regarding safety in the secured unit.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971</p> <p>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 2 (Med Aid cart 2 west front and Nurses cart 2 Central) of 3 carts reviewed for pharmacy services.</p> <p>The facility failed to ensure:</p> <ol style="list-style-type: none"> 1. LVN P, responsible for Med Aid cart 2 west front, counted controlled drugs every shift change. 2. The Nurses cart 2 Central had 1 insulin pen for Resident #24 with an expired opened date. <p>This failure could place residents at risk of not having the medication available due to possible drug diversion.</p> <p>Findings Included:</p> <ol style="list-style-type: none"> 1. Record review and observation on [DATE] at 12:06 PM of Med Aid cart 2 west front, with MA M revealed missing signatures for Off duty and On duty for [DATE], [DATE] of the narcotic count sheet. <p>Interview on [DATE] at 12:08 PM, MA M stated nurses and medication aides should have signed the narcotic sheet after counting the narcotics, she stated she did not work on [DATE], and [DATE].</p> <p>Interview on [DATE] at 1:58 PM, LVN P stated she should have signed the narcotic sheet before and after counting the narcotics on [DATE] and [DATE]. LVN P stated, I counted the narcotics but forgot to sign. LVN P stated this failure could potentially cause a drug diversion.</p> <p>Interview on [DATE] at 2:10 PM, the DON stated she expected nurses to sign the narcotic count sheet at the beginning and at the end of their shift after they completed count with the incoming and off-going nurse. The DON stated if the staff was not signing the narcotic count sheets, she was unable to prove they were counting. The DON stated it was important to ensure a drug diversion did not occur. The DON stated the ADON, and the DON were supposed to check the cart randomly for monitoring.</p> <p>Review of the facility's policy Narcotic Count dated [DATE], reflected the following: .1. The nurse coming on duty and the nurse going off duty must count and justify narcotics supply for each individual resident at the change of each shift. 2. Each nurse counting must record the date and his/her signature verifying that the count is correct on the [Narcotic Count Sheet], at the beginning and end of each shift .</p> <p>2. Record review of Resident #24's Quarterly MDS, dated [DATE], revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, elevated blood pressure, and hyperlipidemia (too many lipids and fats in the blood). She had a BIMS score of 00 indicating her cognition was severely impaired.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #24's physician's orders dated [DATE] revealed an order for Fiasp Flex Touch U-100 Insulin Novolog (insulin aspart) 100 unit /ml (3ml), administer per sliding scale: If blood sugar is 70 to 149, give 0 units.</p> <p>If blood sugar is 150 to 199, give 2 units.</p> <p>If blood sugar is 200 to 299, give 4 units.</p> <p>If blood sugar is 300 to 399, give 6 units.</p> <p>If blood sugar is greater than 399, call MD.</p> <p>Observation on [DATE] at 11:27 AM revealed the Nurses cart 2 Central had a pen of insulin aspart 100 unit /ml for Resident #24 with an expired opened date of [DATE]. Instruction on the pen: discard after 28 days.</p> <p>Interview on [DATE] at 12:00 PM, LVN K stated the pen of insulin belonged to Resident #24 did have an expired open date. LVN K stated she used the pen of insulin in the morning to give 2 units to Resident #24. She stated she forgot to check the open date on the pen. LVN K stated the purpose for putting an open date was for expiration purposes because the insulin was only good for 28 days. She stated after 28 days the insulin would be ineffective.</p> <p>Interview on [DATE] at 12:02 PM, the DON stated the insulin flex pens, once opened, needed to be dated because each insulin pen had a specific days shelf life and if not thrown out before that time the insulin could lose its effectiveness. The DON stated the Assistant DON and the DON were supposed to do random checks of the medication carts for monitoring.</p> <p>Record review of the facility's policy titled Medication - Open Vial Expiration Dates, dated [DATE], revealed in part .Novolog .store under refrigeration until opened. 28 days for opened vial at room temperature or in fridge.</p>		

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 01/15/2025
NAME OF PROVIDER OR SUPPLIER The Meadows Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8383 Meadow Rd Dallas, TX 75231	
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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50910</p> <p>Based on interview, and record review, the facility failed to ensure residents obtained needed dental services, including routine dental services for 2 of 2 residents (Resident #8 and Resident #23) reviewed for dental services.</p> <p>The facility did not obtain routine dental services for Resident #8 and #23.</p> <p>This failure could place the residents at risk by contributing to mouth pain, difficulty eating and weight loss.</p> <p>Findings included:</p> <p>1. Review of Resident #8 Face sheet dated 1/15/25 reflected a [AGE] year-old female with an admitted [DATE].</p> <p>Review of Resident #8's quarterly MDS assessment, dated 12/11/24, reflected she was moderately cognitively impaired with a BIMs of 12. The resident had no impairment to upper or lower extremities. Resident #8's active diagnoses included Anemia (a condition in which the blood does not have enough healthy red blood cells and hemoglobin), and Essential Hypertension (high blood pressure with no identifiable cause). Resident #8 was on a regular diet. Her funding source was Medicaid. No indication of dental issues.</p> <p>Review of Resident #8's physician orders on 1/14/25 revealed physician order dated 3/12/23 May have audiological, dental, ophthalmologist, podiatry, psych, wound care consults and treatment if indicated PRN.</p> <p>Review of Resident #8's comprehensive care plan revised on 10/24/24, reflected .Approach Start Date: 08/23/2023 Approach End Date: 02/08/2025 Dental referral as needed Edited: 12/09/2024 .</p> <p>Interview with Resident #8 on 01/13/25 at 11:15 AM revealed that she needed to go to dentist due to pain and discomfort of two teeth. She reported she had requested it many times and the facility had not done anything. She reported she talked to administrator and nurses and had been asking to see a dentist for a year.</p> <p>Interview with RN D on 1/15/25 at 9:28am revealed Resident #8 never told her she needed to see a dentist. Resident #8 had never complained to RN D about mouth pain. She was unaware of when the last time Resident #8 saw a dentist.</p> <p>Interview with Social Worker on 1/15/25 9:40am revealed no one had requested a referral for dental for Resident #8. She had not been seen at all by a dentist in the past year. All residents at the facility should have been seen by a dentist routinely, but it also depended on their funding source if the dental was covered for each resident. The Dentist, Dental Assistant and Hygienist came to the facility monthly and saw residents on the list the facility provided. The Social Worker stated she compiled the list based on referrals and residents that needed follow-ups.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Review of Resident #23 Face sheet dated 1/15/25 reflected a [AGE] year-old female with an admitted [DATE].</p> <p>Review of Resident #23's quarterly MDS assessment, dated 12/13/24, reflected she was moderately cognitively impaired with a BIMs of 10. The resident had no impairment to upper or lower extremities. Resident #23's active diagnoses Hypertension, Diabetes and Hyperlipidemia (an abnormally high concentration of fats or lipids in the blood). Resident #23's diet should be therapeutic. Her funding source was Medicaid. No dental issues.</p> <p>Review of Resident #23's Physician Order Report dated 1/15/25 revealed no orders for dentals.</p> <p>Review of Resident #23's comprehensive care plan revised on 10/10/24, reflected the care plan did not address resident's dental needs.</p> <p>Interview with Resident #23 on 01/13/25 at 09:37 AM revealed the food served at the facility was hard to eat because she did not have many teeth and the food got stuck in her teeth.</p> <p>Interview with CNA H on 1/15/25 at 9:24am revealed Resident #23 had never complained about her food or teeth to her.</p> <p>Interview with RN D on 1/14/25 at 4:03pm revealed Resident #23 had never told her she needed a referral for a dental. Resident #23 had never complained to her about her food. RN D stated whenever residents say they want to see the dentist she would call the doctor, get an order, enter order in Matrix and will let the social worker know. The social worker was the person responsible to make appointments. The dentist came periodically to the facility to see residents that were on the list, but she did not know how often.</p> <p>Interview with LVN I on 1/15/25 at 9:05am revealed Resident #23 was able to let LVN I know what she needed. Resident #23 had not complained about her teeth or the food. Resident #23 only complained about her head. LVN, I did not know when the last time Resident #23 was seen by a dentist.</p> <p>Interview with Social Worker on 1/15/25 9:48am revealed that Resident #23 had not been referred to the dentist in the last year. She had not been seen by the dentist in the last year.</p> <p>Interview with DON on 1/15/25 at 10:013am revealed she was not sure how often residents should see a dentist, however if a resident complained about issues with teeth, they would put in a dental referral to the social worker. DON also stated that Resident #8' and Resident #23's funding sources were Medicaid. The risk to the resident if they did not have routine dentals was, they could have decay, dental issues, and impaired eating.</p> <p>Interview with Administrator on 1/15/25 at 10:47am revealed the referral process for dentals at the facility was a concern identified; the referral was made to the social worker and then the Social Worker would contact the Dentist to schedule the appointment. He was unsure how often residents should have routine dentals. The risk to the residents if they did not get routine dentals was that they could have tooth loss and decay. He stated he was unaware that Resident #8 and Resident #23 needed to see a dentist.</p> <p>(continued on next page)</p>

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with DON on 1/15/25 at 3:19pm revealed the facility did not have a policy or process for ancillary services like dental. She stated the nurses were responsible for making referrals if the residents have dental issues and social services was responsible for scheduling the dentals. She stated social services was responsible for ancillary services, such as routine dentals.</p> <p>Interview with Social Worker on 1/15/25 at 3:26pm revealed she was responsible for tracking ancillary services like physicals, dentals, and podiatry for residents. She reported she hired in December she was making rounds to get information on what residents' needs were. She stated that she was creating her own audit system for dental, physicals and podiatry to keep track of who has been seen and the last time they were seen. She stated that she had scheduled the dentist to come next week so she could develop a communication system with them. She stated she believed her position was vacant for 3-6 months and there was an interim social worker that would come on Sundays to keep things going. She stated she was not aware of how the Facility was tracking ancillary services or what system they had in place.</p> <p>An interview with Administrator on 1/15/24 3:36pm revealed the social worker's position was vacant for 3 weeks. He stated they had an interim social worker when the last one left, until they found a permanent one. He stated that during the time of transition with the social workers, nurses were responsible for ancillary services. Administrator stated the facility did not have a policy for routine dentals or dental services.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48560</p> <p>Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure food items in the facility kitchen were covered. 2. The facility failed to ensure hot holding temperature were above 135 F for three menu items on the lunch service. <p>This failure could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination.</p> <p>Findings included:</p> <p>Observation on 1/13/2025 at 9:09 AM of the walk-in freezer revealed food items such as cut zucchini, cut carrots, cinnamon rolls, cooked sausages were left open in a plastic bag inside their individual cardboard boxes.</p> <p>Observation on 01/13/25 at 11:56 AM of the tray line temperatures for the lunch service revealed [NAME] A was measuring Holding Temperatures before serving the residents. [NAME] A used cleaned thermometer and sanitized the thermometer between each use. [NAME] A took the temperature of the vegetable for the day Turnip greens. The temperature on the thermometer read 129 F. [NAME] A stated that there was not adequate water in the water bath and added more water to the water bath. She proceeded to measure food temperatures for other lunch menu items. [NAME] A measured temperature for mashed potato and pureed vegetable - the temperature for both items read 133F. [NAME] A remarked , The temperatures [133 F for mashed potato and pureed vegetable] were not too low and it was okay to serve. [NAME] A then proceeded to begin lunch service without checking the temperature for Turnip greens.</p> <p>In an interview on 1/13/2025 at 12:52 PM, [NAME] A revealed it was okay to serve food below 135 as long as it was in the water bath and the water bath was steaming. She added that she was not sure if the temperature needed to be 135 and above before serving to the residents and excused herself to speak with the Dietary Manager. She came back after speaking with the Dietary manager and stated that if the food was not above 135 F , it should not be served to resident since it could make residents sick. She added she knew holding temperature for hot foods should be 135F and above to prevent food borne illnesses , however she was running late for lunch service and proceeded to serve the residents.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 01/14/25 01:27 PM with the Dietary Manager revealed her expectation was all foods in the freezer should be covered appropriately. She said everyone in the kitchen , including the Cooks and herself were responsible to ensure that all foods were covered. She stated that even though the food items are in a cardboard box, if the food items are opened , they needed to be sealed tight. She stated that [NAME] A made her aware of serving food items to residents when the holding temperature for items such as vegetable and mashed potato was below 135 F on 1/13/24 Lunch service. She stated that the cook did not put adequate water in the water bath. She stated she expected the cook to take the food items out of the tray line, cover them, put them in the oven and recheck the temperature to ensure it was above 135 F before serving it to the residents. She added uncovered food items and holding hot foods below 135 F could cause food borne illness in residents. She stated she was responsible for providing in-services to the kitchen staff regarding appropriate food storage.</p> <p>In an interview on 01/15/25 12:15 PM with the Administrator revealed his expectation was all the kitchen staff follow their training and comply with the state and federal food and kitchen sanitation standards that included covering all food items and storing foods at proper temperatures. He stated failure to comply with state or federal regulations for the kitchen could lead to foodborne illness in the residents.</p> <p>Record review of the facility's policy titled, Food Storage policy revised June 1,2019 reflected, Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes and HACCP guidelines .</p> <p>Record review of the facility's policy titled, Food Storage policy revised June 1,2019 reflected, .Serve all hot foods at a temperature of 135 F or greater and all cold food at 41 F or less. Adjust the temperature to account for the time the food will be held prior to service on the steam table and on the tray carts .</p> <p>Record Review of Review of Food and Drug Administration Food Code, dated 2022, reflected, .3-501.19 Time as a Public Health Control. (A) Except as specified under (D) of this section, if time without temperature control is used as the public health control for a working supply of TIME/TEMPERATURE CONTROL FOR SAFETY FOOD before cooking, or for READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is displayed or held for sale or service . (B) If time without temperature control is used as the public health control up to a maximum of 4 hours: (1) Except as specified in (B)(2), the FOOD shall have an initial temperature of 5 C (41 F) or less when removed from cold holding temperature control, or 57 C (135 F) or greater when removed from hot holding temperature control.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971</p> <p>48560</p> <p>Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 resident (Resident #53) of 8 residents observed for infection control and for 2 of 2 clean linen closets observed for sanitary environment.</p> <p>The facility failed to ensure:</p> <ol style="list-style-type: none"> Clean linen closets were kept sanitary. CNA N failed to performed hand hygiene and changed gloves during incontinent care for Resident #53. <p>These failures could place residents at risk of cross-contamination resulting in infections.</p> <p>Findings included:</p> <p>1- An observation of the Clean Linen Closet in the Secured Unit, on 1/13/25 at 10:58 AM revealed an additional cart with a broken bottom most shelf apart from the clean linen cart. The cart had the following items on it: The top shelf contained 2 sets of bagged clothes without names/identification. The second shelf was taped off with several white tapes and had a toothpaste and shaving cream. The third shelf had clean linens on it. The clean linen cart had a black vest hanging on the side of it.</p> <p>In an observation and interview on 01/13/25 at 11:00 AM with ADON B stated that clean linen closet should only contain clean linens. She was not sure about the other cart in the clean linen closet. She stated that other carts/ vests/ items in the clean linen closet posed a potential risk of cross-contamination.</p> <p>In an interview on 01/13/25 at 11:15 AM with Laundry Personnel J, she stated that Laundry was responsible for the clean linen cart only. She was not sure who kept the other cart in the clean linen closet and stated it looked like CNA cart. She stated that anything except clean linen can put the residents at a risk of infections.</p> <p>In an interview on 01/13/25 11:20 AM with CNA E revealed she worked at the facility for about 3 months. She stated that she did not know who put it there or what purpose the other cart had in the clean closet room. She stated she had always seen the other cart in the clean linen closet. She stated that personal hygiene items on the cart if not bagged or any other items were considered dirty and as a potential source of an infection to the residents.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In another observation on 01/14/25 at 10:06 AM in a different unit of the nursing facility, revealed a cardboard box that contained an empty denture box and 2 bottles of mouthwash. The cardboard box was resting near the clean linen cart.</p> <p>In an interview and observation on 01/14/25 at 10:09 AM, RN D stated that there should not be anything in the clean closet room except residents washed and clean linens. She stated that she did not know who put the box there. She stated that increases the risk of infection to the residents and carried the box out of the clean closet to disposed it off.</p> <p>In an interview on 01/15/25 at 11:27 AM, the DON stated she expected laundry staff to ensure only clean linens were in the Clean Linen Closets. She said any other items such as personal hygiene items, clothes, carts posed a potential risk of cross-contamination and possible skin issues. She stated that ADON and herself were responsible for ensuring safe practices were utilized to minimize infection control.</p> <p>2- Record review of Resident #53's Comprehensive MDS assessment dated [DATE] reflected Resident #53 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included dementia, muscle wasting and atrophy, and need for assistance with personal care. Resident #53's BIMS score of 6, which indicated Resident #53's cognition was severely impaired. The MDS assessment indicated Resident #53 required maximal assistance with toileting and personal hygiene.</p> <p>Record review of Resident #53's Care Plan dated 10/24/24, reflected the following: Problem: Resident #53 has total urinary incontinence Goal: Resident #53 will remain free from skin breakdown due to incontinence . Approach: . Check resident every 2 hours and as needed incontinence. Change clothing as needed after incontinence episodes .</p> <p>Observation on 01/14/25 at 10:21 AM revealed CNA N entered Resident #53's room to provide incontinence care. CNA N washed her hands and donned gloves, she unfastened Resident #53's brief, she cleaned his front pubic area with wipes. CNA N changed her gloves without performing any kind of hand hygiene. She rolled the resident on his side revealing medium bowl movement. CNA N wiped the resident's buttock area with peri-wipes, front to back, removing the fecal material. CNA N then removed the soiled brief and with soiled gloves, placed the clean brief under the resident. CNA N changed her gloves without hand hygiene. She rolled the resident on his back onto the clean brief. She applied skin barrier cream to the groins area. She changed gloves without hand hygiene. Once finished, she fastened the resident's brief.</p> <p>In an interview on 01/14/25 at 10:41 AM, CNA N stated she should have changed her gloves and performed hand hygiene when she went from dirty to clean. CNA A stated failing to provide proper care exposed the resident to infections. She stated she was nervous, and she was trained to sanitize hands between change of gloves.</p> <p>In an interview on 01/14/25 at 12:02 PM , the DON who was the infection control preventionist, stated she expected the staff to remove their gloves and sanitize their hands when going from dirty to clean. She stated failure to do so would potentially lead to cross-contamination and possible spread of infection. She stated that ADON and herself were responsible for ensuring safe practices were utilized to control infection spread by doing routine rounds and random checks.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility policy titled, Infection Control - Prevention and Control Program dated 12/2018, reflected, The intent of this program is to assure that the home develops, implements, and maintains an Infection Prevention and Control Program to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. The program will: . 5. Properly store, handle, process, and transport linens to minimize contamination .</p> <p>Record review of the facility's policy, Hand Washing, dated December 2018, reflected, .Employees must wash their hands for at least twenty seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: . Before and after assisting a resident with personal care . After removing gloves or aprons .</p>