STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455601	A. Building B. Wing	07/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alvarado Meadows Nursing & Rehabilitation	101 N Parkway Alvarado, TX 76009

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately notify the resident's representative(s) when there was a significant change in the resident's physical and psychosocial status for one (Resident #1) of six residents reviewed for changes in condition.1. The facility failed to notify Resident #1's RP of Resident #1's antibiotic order for a skin infection on 05/31/26.2. The facility failed to notify Resident #1's RP of treatment for head lice 06/08/26.These failures could put residents at risk of not having their care needs and health changes communicated and addressed with their responsible party.Findings included:Record review of Resident #1's admission MDS dated [DATE] reflected she was admitted on [DATE] with diagnoses of Urinary tract infection, Vitamin B deficiency, weight loss, and visual hallucinations. Resident #1 had a Bims score of 3, indicating she had severe cognitive impairment. She required to set up clean up assistance with eating and supervision with dressing and grooming.Record review of Resident #1's physicians ?orders reflected on 5/31/26 a new physicians order was received for Cephalexin (an antibiotic used to treat infection) 500mg 1 capsule by mouth four times a day related to a diagnosis of cellulitis (a subcutaneous skin infection). Record review of Resident #1's nursing progress notes reflected there was no documentation on 5/31/26 of family notification related to new physicians' order or change in residents condition related to new diagnosis of cellulitis. Record review of Resident #1's physicians' orders reflected on 6/08/26 a new physicians order was received for Ivermectin (an antiparasitic used to treat head lice) External Lotion 0.5 % Apply to scalp topically one time for infestation for 1 day apply 4 oz to dry hair, rinse off after 10 minutes with water. Record review of Resident #1's nursing progress notes reflected on 6/08/26 there was no documentation of family notification related to new physicians' order or change in residents condition related to new order for Ivermectin. Record review of Resident #1's admission record dated 7/2/26 reflected emergency contact #2 was accurate and verified by family member interview. In an interview on 7/2/26 at 10:50 am Resident #1's responsible party/emergency contact #1 stated she was upset that the facility had not notified her of Resident #1's recent infection to her lower leg and treatment of lice in her hair. She stated she was shocked at the residents' condition upon her arrival at the facility. She stated the staff should have called and reported any changes in condition to her. She verified the emergency contact #1 had an incorrect phone number and then verified emergency contact #2 had a correct phone number. She stated neither were notified of changes in Resident #1's condition. In an interview on 7/2/26 at 3:21p.m., the DON said Resident #1's emergency contact #2 updated his phone number on 05/18/26 at his last visit. She stated the facility nurses had been trying for months to get an accurate phone number and address for both emergency contact #1 and #2. She finally saw the family member in the facility and stopped him and requested an accurate number to which she received at that time and updated the chart. She was not sure why no notification happened after the new number was obtained. She stated her expectation for notifying residents responsible party was that they be notified of any changes in residents' condition including new physicians' orders and treatments. She stated all attempts of family contact successful and unsuccessful should be documented in the resident's medical record. The DON stated (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the staff had been educated on family notification of changes in conditions. She stated she was responsible for monitoring nursing documentation. The DON stated negative effects for failing to notify representatives or families of changes in condition and new orders would be a lack of communication, loss of trust and credibility. In an interview on 7/2/26 at 3:39p.m., the ADM stated it was expectation that nurses would contact responsible party representatives or families when changes in residents' condition occur. She stated if a charge nurse were unable to contact the family, she expected the nurse to notify the DON or ADM. She stated nursing staff were trained on notifying contacts of changes in condition by the DON. The DON was responsible for monitoring and making sure documentation was in the chart with chart audits and daily review of orders. She stated negative effects for failing to notify responsible parties would be that it makes families angry. Record review of undated facility policy titled Notifying the Physician of Change in Status reflected. The resident' s family member or legal guardian should be notified of significant change in resident ' s status unless the resident has specified otherwise. The nurse will document all attempts to contact the physician, all attempts to notify the family and/or legal representative of family notification of new order or change in condition related to new DX, the physician' s response, the physician orders, and the resident' s status and response to interventions.