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	03/06/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview, and record review, the facility failed to ensure each resident had the right to be free from abuse for 2 of 7 residents (Resident #7 and Resident #22) reviewed for Resident Rights. CNA G verbally abused Residents #7 and #22 when the residents requested to return inside the building following a smoke break, and she yelled at them telling they could not go inside and blocked the door. The failure placed residents at risk of feelings of decreased self-worth. The non-compliance was identified as PNC. The noncompliance began on 02/15/25 and ended on 02/21/25. The facility had corrected the non-compliance before the investigation began. Finding included: Record review of Resident #7's face sheet dated 03/06/25 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #7's entry MDS sheet dated 02/08/25 reflected a BIMS score of 13 indicating her cognition was intact. Resident #7's functional abilities indicated she required substantial/maximal assistance with toileting hygiene, shower/bathing and lower body dressing. Resident #7 was independent with eating, oral hygiene and upper body dressing, and partial assistance with personal hygiene. Resident #7's diagnoses included acquired absence of left leg above knee, muscle weakness, lack of coordination, and a history of falling. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455601	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Alvarado Meadows Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 101 N Parkway Alvarado, TX 76009	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #7's care plan as of 02/16/25 reflected Resident #7 was a smoker. The care plan reflected a goal to smoke in designated areas without occurrence of injury. The care plan interventions included perform smoking assessment according to facility policy. Explain/Show where designed smoking area was, and smoking times-repeat as needed. Monitor as needed when smoking to assure resident safety, keep all smoking material at nurse's station. The care plan reflected Resident #7 had a history of trauma that may have a negative impact. The trauma was related to being angry at CNA G for saying that she could not go back inside after smoking. The care plan goal included maintain resident's safety and integrity during post trauma episode, using appropriate interventions. The care plan interventions included to arrange a licensed mental health provider as ordered by the physician. Identify situation/event/images that trigger recollections of the traumatic event and limit the resident's exposure to these as much as possible. These triggers could include verbal threats, and physical aggression. Record review of Resident #7's Safe Smoking assessment dated [DATE] and 03/04/25 reflected in summary: This resident required direct supervision while smoking: All smoking materials will be kept at the nurse's station: The evaluation has been explained to the family responsible party and to the resident. Record review of Resident #22's face sheet dated 03/06/25 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #22's entry MDS sheet dated 02/19/25 reflected a BIMS score of 15 indicating her cognition was intact. Resident #22's functional abilities indicated she was independent with eating, oral hygiene, toileting hygiene and required set up or clean up with shower/bathing, upper and lower body dressing, and personal hygiene. Resident #22 had use of a walker. Resident #22's diagnoses included muscle weakness and difficulty walking. Record review of Resident #22's care plan as of 02/16/25 reflected Resident #22 was a smoker. The care plan gooal included to smoke in designated areas without occurrence of injury. The care plan interventions included perform smoking assessment according to facility policy. Explain/Show where designed smoking area was, and smoking times-repeat as needed. Monitor as needed when smoking to assure resident safety, keep all smoking material at nurse's station. The care plan reflected Resident #7 had a history of trauma that may have a negative impact. Record review of Resident #22's Safe Smoking assessment dated [DATE] reflected in summary: This resident required direct supervision while smoking: All smoking materials would be kept at the nurse's station: The evaluation has been discussed with the resident. Interview on 03/04/25 at 10:55 AM with Resident #7 revealed she liked to smoke at each smoke break. Resident #7 stated she was outside smoking with CNA G and finished earlier than others and wanted to return inside the facility. According to Resident #7, CNA G yelled at her saying, You can't go back inside until I go in. Resident #7 stated it made her upset. Resident #7 stated it was cold outside, and she should have been allowed to return inside the building if she wanted. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/04/25 at 1:40 PM with Resident #22 revealed she enjoyed smoking on the smoke breaks provided by the facility. According to Resident #22, she was outside when CNA G would not allow Resident #22 to return inside the building when she was finished smoking. Resident #22 stated CNA G was the only staff member, who would make residents stay outside until everyone was finished, and they all came back inside at one time. Resident #22 stated she was upset that CNA G did not allow residents to return inside the building yelling, Do not go any further. No one can go in without me. Resident #22 also stated CNA G stood in the walkway blocking residents from leaving the patio. Resident #22 stated she reported to the front desk that Resident #7 was not allowed to return to the building and the Administrator followed up with her about the incident. According to Resident #22, CNA G no longer worked at the facility and there had not been any further issues with residents returning inside the building when they were finished smoking. Observation on 03/04/25 at 4:10 PM revealed residents on the patio with the Maintenance Director and revealed residents were able to exit the patio once they were finished smoking. Observation and interview on 03/05/25 at 4:00 PM with the Laundry Aide revealed there was a schedule sheet that he followed which notified when his department took residents out to smoke. The Laundry Aide stated he recognized all residents were able to safely smoke. Laundry Aide stated he was responsible for ensuring all residents were safe before, during, and after smoking and should stay together just in case they needed help returning to the facility, for example if they were a fall risk. The Laundry Aide stated he thought all residents were supposed to wait together to go inside the building after smoking, but he could not stop anyone from going back inside the building if they wanted to leave. Therefore, he allowed residents to leave when they were done smoking. According to the Laundry Aide, trying to stop residents from returning inside the building after smoking would go against their rights to move around as they want. Interview on 03/05/25 at 4:41 PM with RN I revealed she was aware of residents that smoked. There was a schedule that indicated nursing staff were responsible to take residents out during the evening hours. According to RN I, she was present on 02/15/25 when CNA G volunteered to take the residents out to the patio for smoking at 6:30 PM. RN I stated she was standing at the nursing station when Resident #22 informed RN H that Resident #7 wanted to return back into the building once she finished smoking and she was not allowed to and was told she had to wait. RN I stated according to Resident #22, she did not like that Resident #7 was told she could not leave, and that CNA G blocked the walkway to prevent anyone from leaving the patio. RN I stated she and RN H then began contacting the DON and the Administrator. Interview on 03/05/25 at 5:09 PM with the ADON revealed she was in-serviced on resident rights after the 02/15/25 incident when CNA G would not allow residents to reenter the building after smoking. The ADON stated whomever was scheduled to take residents out to smoke was responsible for residents while they were smoking. The ADON stated if there were multiple residents smoking and one wanted to come back inside, and you did not have to leave residents smoking unsupervised, residents who were able to safely return to the building could do so. The ADON expressed that residents had the right to be able to return in the building after smoking, or anytime they wanted to come inside or move about the facility, not doing so violated their rights. (continued on next page)

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Alvarado Meadows Nursing & Rehabilitation	101 N Parkway Alvarado, TX 76009

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Interview on 03/06/25 at 9:10 AM with RN H revealed she was at the nursing station on 02/15/25 when CNA G took residents who smoke out to the patio at their 6:30 PM smoke break. RN H stated after the break, Resident #7 and Resident #22 reported to her that CNA G told them they could not come back in inside the building until everyone was done smoking. RN H stated, it was cold that night so residents were distraught they could not return in the building once they were done smoking. RN H stated she reported to the Administrator and the DON, what residents reported to her. RN H stated she was in-serviced on resident rights and the residents had the ability to move about the facility, being told they could not return in the building after they were ready, placed them at risk of their rights being violated.

Interview on 03/06/25 at 10:00 AM with the Administrator revealed he was notified by RN H that CNA G took residents out to smoke; once they were finished smoking and wanted to return inside the building because they were cold. The Administrator stated he was told CNA G yelled No one can go in without me and stood in the walkway preventing them from leaving the patio. The Administrator stated he asked residents to be assessed to ensure they were ok and not harmed in any way and to gather statements. The Administrator stated he alerted his corporate office and the human resources and suspended CNA G. The Administrator stated he entered the facility on 02/16/25 to interview residents and started in-services and monitoring. The Administrator stated there was a schedule to advise which department was responsible for taking the residents out to smoke at designated times. The Administrator advised he expected staff to allow residents to go out on the patio and smoke, if they were done and wanted to come back inside the building staff should allow that as it was their right to do so. The Administrator stated they completed in-services to educate staff to monitor residents while outside on the patio during smoking breaks; however, you could not keep residents outside against their will.

Interview on 03/06/25 at 10:07 AM with the DON revealed she was notified of the incident on 02/15/25 with CNA G refusing to allow residents to return in the building by standing in the walkway and yelling they had to wait on all residents to reenter together. The DON stated in-services on resident rights, abuse and neglect, and their smoking policy were started immediately. The DON stated she expected staff to follow the smoking schedule and take residents out to smoke. The DON stated at any time residents want to leave the patio after smoking, they have the right to do so and should be able to do so. The DON stated CNA G not allowing residents to return inside the building placed them at risk of not having their rights honored.

Interview on 03/07/25 at 11:39 AM with CNA G revealed she did take residents out to the patio for a smoke break right before her shift ended at 6:30 PM on 02/15/25. According to CNA G it was a bit cooler that evening, and Resident #7 attempted to leave the patio when she finished smoking. CNA G stated she expressed to Resident #7 you have to wait to go inside all together. CNA G stated the reason she did not allow residents to leave the patio was because it was not feasible. She stated Resident #7 was in a wheelchair and could have fallen. CNA G stated, I admit I kept her from going in. It was for her safety. According to CNA G, she was responsible for ensuring residents returned in the building safely. CNA G stated she was suspended and later terminated. CNA G stated she was not thinking residents were placed at risk of rights not being honored, she stated I was thinking of their safety.

Record review of a Employee Disciplinary Report for CNA G dated 02/15/25 reflected due to allegations, CNA G will be placed on unpaid investigatory suspension and will remain on investigatory suspension until the investigation is completed. CNA G will be notified when the investigation is 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #7's statement reflected: 6:30 Smoke Break At the 6:30 PM smoke break CNA G took the smokers outside the smoke area. When I was done smoking, I started to go back inside from the smoking area and CNA G stood in the opening that leads to sidewalk and said You can't go in until I go in. I stayed outside in the smoking area for about 15 minutes. I was cold and I did not have a coat on. When I came back inside, I told RN H and RN I what happened. Record review of Resident #22's statement reflected: 6:30 PM Smoke Break At the 6:30 PM smoke break CNA G took us outside. Before we went outside, she was talking really fast, and I could tell that she did not want to take us outside and stated she had other things to do. She did take us outside but kept coming back inside and to the smoke area. She was pacing back in forth in the smoke area and was yelling I do not want to talk to anyone. I am upset. Two of the smokers were finished and started to go down the sidewalk to go back inside like they normally do, and CNA G yelled Do not you go any further. No one can go in without me. She said she was going to search for everyone's lighters and cigarettes. I did not see her search anyone. CNA G stood in front of Resident #7 and would not let her leave the smoking area. I was still smoking. Another resident told her he was going inside when he finished his cigarette, and he went inside. CNA G was very short spoken with us while we were outside. When I returned to the building, I told RN H and RN I what happened during the smoke break. Once in my room I checked my cell phone, and I had a missed call from CNA G, I did not call her back. Record review of CNA G's Witness Statement reflected: I work every time I am asked to, I work nights, I worked my Saturday day off. Residents all they want to do is smoke, I have COPD. This was signed by CNA G 02/17/25 and the Administrator. An ADHOC QAPI meeting was held on 02/17/25 with the Interdisciplinary Team including the Medical Director to discuss the allegations and findings. Record review of the facility's Provider Investigation Report, completed by the Administrator on 02/21/25, reflected: Description of Allegation: [CNA G], CNA, took the residents out to smoke at the schedule[d] 6:30 PM time. Some of the residents were getting cold and wanted to go back inside after smoking a cigarette. [CNA G] yelled and told them that they couldn't go back inside without her, and she wasn't letting anyone back in until she was ready. [Residents #7 and #22] stated they felt this was verbal abuse by [CNA G] yelling and not letting them back inside. Provider Response: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Details of this incident were found out after the staff member [CNA G] left after her shift. The staff member was immediately suspended pending investigation after administration found out about the incident. Safe surveys for smokers completed. Investigation Summary: Investigation summary shows that the incident did occur. [CNA G] was terminated on 2/18/2025 for verbal abuse occurring. Residents did not have any trauma from the incident. Provider Action Taken Post Investigaiton: In-serviced staff on abuse/neglect. [CNA G] was terminated for verbal abuse on 2/18/2025. No adverse effects for any residents involved. Record review of Payroll Input/Personnel Action Form signed 02/18/25 reflected CNA G was terminated on 02/18/25. CNA G has failed to adhere to the Corporate Code of Conduct. CNA G was aware of the corporate code of conduct as indicated by the signature of the employee handbook acknowledgment. CNA G meet criteria for immediate termination. Record review of an in-service record, dated 02/15/25 reflected the DON trained staff on the following topics: Abuse and Neglect, Resident Rights, and Smoking Policy. The in-service record reflected staff not present would receive the in-service training prior to assuming their duties on their next scheduled shift. Also, new and agency staff would received the in-service training prior to assuming patient care duties. Interviews on 03/06/25 with LVN A, LVN B, RN H, RN I, Laundry Aide, Dietary Aide, DON, ADON, CNA J revealed they had been trained on residents' rights and were aware to allow residents to return in the building as they were finished smoking, not doing so placed residents at risk of violation of their rights being honored. Record review reflected the facility implemented the following for monitoring from 02/16/25-02/21/25: ask 15-20 staff members per week; ask about 5 resident per week how staff is treating them; during incident/event review in standup; during facility rounds are there any sings of staff acting rudely or inappropriate with residents. Record review of the facility's Resident Rights policy, revised 11/28/16, reflected: Exercise of Rights - The resident has the right to exercise his or her rights as a resident of the facility and as citizen or resident of the United States. Respect and dignity - The resident has a right to be treated with respect and dignity, including: The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Self-determination - The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice. 1. The resident has a right to choose activities, schedule and health care and providers of health care services consistent with his or her interest. 2. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43791 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 rights for four residents of 12 residents (Residents # 28, #29, #33, and #47) reviewed for care plans. The facility failed to ensure Residents # 28, #29, #33, and #47 care plans were complete and accurate. These failures could place the residents at risk of not receiving appropriate care. Findings included: 1. Record review of Resident #28's undated Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included chronic kidney disease, morbid obesity, and muscle wasting. Record review of Resident #28's quarterly MDS, dated [DATE], reflected a BIMS score of 15, indicating she was cognitively intact. Her Functional Abilities assessment indicated she was totally dependent on staff for toileting and needed maximum assistance with bathing and personal hygiene. Record review of Resident #28's care plan, dated 01/20/25, reflected she had impaired cognitive function/dementia or impaired thought processes which was not reflected in her diagnoses. Her care plan also reflected she was resistive to care related to mild cognitive impairment if uncertain etiology, which was again not reflected in her BIMS score. 2. Record review of Resident #29's undated Admission Record reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included Schizoaffective disorder-bipolar type, diabetes, left sided paralysis from a stroke, and anxiety. Record review of Resident #29's quarterly MDS, dated [DATE], reflected a BIMS score of 9 indicating she had moderate cognitive impairment. Her Functional Abilities assessment reflected she was totally dependent on staff for all ADLs except eating and oral hygiene. Record review of resident #29's care plan, dated 03/04/25, reflected she was allergic to (no allergies listed, resident is allergic to penicillin), and an ADL self-care deficit. 3. Record review of Resident #33's undated Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included right sided paralysis related to a stroke, liver disease, seizures, and Schizoaffective disorder. Record review of Resident #33's quarterly MDS, dated [DATE], reflected a BIMS score not assessed. Her Functional Abilities assessment indicated she was totally dependent on staff for her ADLs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #33's care plan, dated 02/24/25, did not reflect she had a self-care deficit related to her stroke and paralysis. 4. Record review of Resident #47's undated Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included chronic kidney disease, bone infection of the spine, paraplegia (paralyzed from waist down), and heart failure. Record review of Resident #47's admission MDS, dated [DATE], reflected only section A had been completed. Record review of Resident #47's care plan, dated 03/01/25, reflected she had hemiplegia related to (not indicated), she was at risk for falls related to (not indicated), potential fluid deficit related to (not indicated), and allergic to (not reflective of Aspirin, codeine, lisinopril, Septra, lithium, and NSAIDs allergies) Interview on 03/06/25 at 10:25 AM with LVN A revealed Residents #33 required total care did not get out of bed. She stated she did not know who was responsible for the care plans, but she thought it was the ADON. She could not state a risk for care plans not being accurate. Interview on 03/06/25 at 11:00 AM with LVN B revealed the baseline care plans were initiated by the admitting nurse, and then the DON and the MDS nurse completed the comprehensive care plan. She stated it was necessary for the care plan to be up-to-date and accurate, so the resident's needs were addressed. Interview on 03/06/25 at 1:03 PM with the DON revealed the interdisciplinary team was responsible for updating care plans during the resident's stay. She stated the risk of care plans not being complete could be anything. The RNC, who was present, interjected and stated care plans should be complete, accurate, and personalized to the resident in order to assure all needs and conditions of the resident were being met. She stated failing to do so could result in residents not receiving complete care. The care plans were updated when there was a change in condition or new orders were received. Record review of the facility's current, undated Comprehensive Care Planning policy reflected: Each resident will have a person-centered comprehensive care plan developed and implemented to meet his preferences and goals, and address the resident's medical, physical, and psychosocial needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview, and record review the facility failed to ensure residents who are unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 5 of 12 residents (Residents #28, #31, #33, #47, and #56) reviewed for personal hygiene. The facility failed to ensure Residents #28, #31, #33, #47, and #56 received assistance with bathing, grooming, and personal hygiene. These failures could result in the resident having decreased sense of self-worth. Findings included: 1. Record review of Resident #28's undated Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included chronic kidney disease, morbid obesity, and muscle wasting. Record review of Resident #28's quarterly MDS, dated [DATE], reflected a BIMS score of 15, indicating she was cognitively intact. Her Functional Abilities assessment indicated she was totally dependent on staff for toileting, and needed maximum assistance with bathing and personal hygiene. Record review of Resident #28's care plan, dated 01/20/25, reflected she had an ADL self-care performance deficit related to impaired balance with an intervention of Bathing: the resident requires assistance with bathing 3x a week, and as necessary. Interview on 03/04/25 at 10:02 AM with Resident #28 revealed she only got bathed every two weeks because there was only one CNA on the evening shift, which was when her bath was scheduled. Staff would not bathe her unless she demanded it. She stated not being bathed made her feel uncomfortable so she didn't go out of her room much. Record review of Resident #28's bathing task record from 2/09/25 to current date reflected she had been bathed twice (2/22/25 and 2/23/25). All other dates were documented as Activity did not occur. 2. Record review of Resident #31's undated Admission Record reflected the resident was a [AGE] year-old male admitted to the facility on [DATE], with diagnoses which included heart failure, diabetes, seizures, and stroke. Record review of Resident #31's admission MDS, dated [DATE], reflected a BIMS score of 11 indicating he had mild cognitive impairment. His Functional Abilities assessment indicated he required maximum assistance with bathing and toileting. Record review of Resident #31's care plan, dated 02/22/25, reflected he had an ADL self-care deficit with an intervention for bathing to have 1 staff to assist. (continued on next page)

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

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 03/04/25 at 9:41 AM with Resident #31 revealed he had not been bathed in over a week. The resident's hair was unkempt and appeared greasy. The resident stated he asked the CNAs to shower him. He stated they would say they would do it, but they never came back, so it never happened. He stated he did not need a lot of attention, but there still did not seem to be enough staff to help the residents. Record review of Resident #31's bathing task record from 02/05/25 to current reflected he had been bathed twice (02/06/25, and 02/18/25), all other dates were documented Activity did not occur. 3. Record review of Resident #33's undated Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included right sided paralysis related to a stroke, liver disease, seizures, and Schizoaffective disorder. Record review of Resident #33's quarterly MDS, dated [DATE], reflected a BIMS score not assessed. Her Functional Abilities assessment indicated she was totally dependent on staff for her ADLs. Record review of Resident #33's care plan, dated 02/24/25, did not reflect she had a self-care deficit related to her stroke and paralysis. Observation on 03/04/25 at 10:00 AM revealed Resident #33 appeared to be asleep. Her hair was unkempt and appeared greasy. Record review of Resident #33's bathing task record from 02/05/25 to current reflected she had been bathed on 02/26/25. All other dates were documented as Activity did not occur. Phone interview on 03/05/25 at 1:57 PM with Resident #33's family member revealed they were at the facility almost every evening to visit with the resident. The resident did not respond to anyone unless she knew them, but she was unable to do anything for herself. They stated they knew for sure the resident had not been bathed in the last four days. They stated the staff were always busy, and they rarely came to her room when they were there to check on the resident. The family member stated they had to seek out staff to change the resident's brief, and it still took a while for them to come change her. He stated there did not appear to be enough staff to care for the residents. 4. Record review of Resident #47's undated Admission Record reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included chronic kidney disease, bone infection of the spine, paraplegia (paralyzed from waist down), and heart failure. Record review of Resident #47's admission MDS, dated [DATE], reflected only section A had been completed. Record review of Resident #47's care plan, dated 03/01/25, reflected she had an ADL self-care deficit with an intervention for bathing to have 1 staff assist. Interview on 03/04/25 at 10:07 AM with Resident #47 revealed she had not been bathed since she was admitted (02/08/25) and did not know there was a shower schedule. She stated she would like to be bathed twice a week at least. She stated she felt very dirty and her hair needed to be washed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455601	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER: Alvarado Meadows Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 101 N Parkway Alvarado, TX 76009	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of resident #47's bathing task record from 02/09/25 to current reflected she had not been bathed. All dates were documented as Activity did not occur. 5. Record review of Resident #56's face sheet dated 03/06/25 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] and readmitted [DATE]. Record review of Resident #56's MDS sheet dated 12/24/24 revealed a BIMS score was not entered because Resident #56 was unable to complete the interview. Resident #56 functional abilities indicated she required substantial/maximal assistance with toileting hygiene, shower/bathing and personal hygiene. Resident #56's diagnoses included urinary tract infection (infection that affects part of the urinary tract), Type 2 Diabetes (high blood sugar), Dementia (group of symptoms affecting memory), abnormalities of gait and mobility, lack of coordination , and unsteady on feet. Record review of Resident #56's care plan as of 08/06/24 revealed Resident #56 had an activities of daily living self care performance deficit due to dementia. Goal included the resident will maintain or improve current level of function in transfers, eating, dressing, toilet use and personal hygiene. Interventions included resident uses a geri chair, Transfer: the resident required (X2) staff participation with transfer. Bathing: provide the resident with a sponge bath when shower can not be tolerated. Resident was totally depend on staff to provide a bath (3x a week) and as necessary. The Resident required (x1) staff participation with bathing. Interview on 03/04/25 at 3:36 PM with a family member of Resident #56 revealed she visited with Resident #56 daily. The family member stated she would find her soaked in her brief down to the sheets with urine and poop everyday, leaving her with an odor. According to the Family Member when she entered the facility, she would have to take matters into her own hands to clean and change Resident #56 along with her bedding. The Family Member stated they are very understaffed and do not have staff on the hall to care for the residents, it made me upset to see how they just leave my mom like that. The Family Member stated Resident #56 was on hospice which came in the mornings to bath, change and dress her for the day, however there was no one from the facility that checked on Resident #56 throughout the day to ensure she was dry or changed. The Family Member stated it would be nice to have someone check on her after lunch to change her brief. Interview on 03/05/25 at 10:25 AM with LVN A revealed residents were showered or bathed three times a week by the CNAs. She stated the CNAs bring her their shower sheets to the nurse if there is a new finding like a bruise, or if the resident refuses their shower. She would check with the resident and encourage them to be bathed. She stated the risk of not getting bathed was skin breakdown and irritation. Interview on 03/05/25 at 12:43 PM with the DON revealed showers and baths were documented in the computer under Tasks by the CNAs. She stated if it was not in the computer it did not happen. She stated there were no shower sheets. Interview on 03/06/25 at 8:20 AM with the RNC revealed they had stacks of old shower sheets from several months, going back to before the change of ownership. She stated the current policy was for the staff to document everything in the computer because shower sheets get lost, and were difficult to track. She stated the expectation was the CNAs would bathe residents three times a week, less if the resident preferred it. All documentation was to be done in the computer. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/06/25 at 3:25 PM with CNA C revealed residents should be showered three times a week. When she showered a resident she filled out a shower sheet and turned it into the nurse. If a resident refused a shower she had them sign the shower sheet. She stated the risk of a resident not being showered was skin irritation or breakdown. Interview on 03/06/25 at 3:30 PM with the DON and the RNC revealed they both stated the CNAs did not use a shower sheet to document showers. They documented showers in the computer under Tasks. The DON and the RNC both stated the Task document was the most accurate record of the resident's showers. The DON stated the residents were being bathed, but if they were not the risk could be anything. Interview on 03/06/25 at 3:47 PM with CNA D revealed the residents should be showered three times a week. She stated she documented her showers on a shower sheet and then put it into the computer. The shower sheet was given to the nurse if there were findings like a bruise or redness found during the shower. She stated the risk of residents not being bathed was skin breakdown or irritation. Interview on 03/06/25 at 3:58 PM with CNA E revealed residents were showered three times a week. She documented her showers on a shower sheet and then put it into the computer. The shower sheet was then given to the nurse. She stated the risk of residents not being bathed could be skin breakdown. Interview on 03/06/25 at 4:04 PM with CNA F revealed she was supposed to be the designated shower aide Monday through Friday, but she was often called to be a CNA on one of the halls because someone called in. She stated she usually only had one day a week when she was functioning as the shower aide because the CNAs called in so often. Record review of the facility's current, undated Bath, Tub/Shower policy reflected: Bathing by tub bath or shower is done to removed soil, dead epithelial cells, microorganisms from the skin, and body odor to promote comfort, cleanliness, circulation, and relaxation Frequency and type of bathing depends on resident preference, skin condition, tolerance, and energy level. Although daily bathing or shower is preferred and necessary for some, the aging skin can be maintained by bathing every two days or with partial bathing as needed