STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675151	A. Building B. Wing	01/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Care Center	632 Windsor Way Van Alstyne, TX 75495

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure assessments accurately reflected the resident's status for eight (Residents #1, #2, #3, #4, #5, #6, #7, and #8) of twenty-nine residents reviewed for accuracy of assessments.The facility failed to ensure Resident #1's, #2's, #3's, #4's, #5's, #6's, #7's, and #8's Comprehensive MDS Assessments accurately reflected the residents were using mechanical lifts. This failure could place residents at risk for not receiving care and services needed to meet their needs, diminished function of health, and regression in their overall health.Findings included:1. Record review of Resident #1's Face Sheet, dated 01/29/2026, reflected a [AGE] year-old female, admitted [DATE], diagnoses included muscle weakness, unsteadiness of feet, lack of coordination, convulsion (sudden, irregular movement), and history of fall.Record review of Resident #1's Comprehensive MDS Assessment, dated 11/17/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment did not indicate the resident was using a mechanical lift (a device used to lift, transfer, or position an individual with limited mobility).Record review of Resident #1's Comprehensive Care Plan, dated 11/23/2025, reflected the resident was at risk for falls related to unsteady gait, history of falls, muscle weakness, and cognitive impairment. The Comprehensive Care Plan also reflected, with revision date, 12/31/2025, staff were to use adaptive equipment (e.g., utensils, transfer aids, non-skid footwear) to enhance participation for ADLs. The plan did not indicate what transfer aid to use.Record review of Resident #1's Physician Order reviewed on 01/29/2026 reflected the resident did not have an order for sit-to-stand (a mobility device that helps an individual with some strength but limited endurance to safely move from a seated position to a standing position).During an interview on 01/29/2026 at 8:41 a.m., Resident #1 stated some staff would transfer her using a machine. She said she used the machine last year, but she could not remember the exact date.2. Record review of Resident #2's Face Sheet, dated 01/30/2026, reflected a [AGE] year-old female, admitted [DATE], diagnoses included muscle weakness and lack of coordination.Record review of Resident #2's Comprehensive MDS Assessment, dated 12/02/2025, reflected the resident was cognitively intact (resident capable of normal cognition and needed little support) with a BIMS score of 15. The Comprehensive MDS Assessment did not indicate the resident was using a mechanical lift.Record review of Resident #2's Comprehensive Care Plan, dated 01/07/2026, reflected the resident was at risk for falls related to muscle weakness and one of the interventions was to be assisted with transfers via mechanical lift (used to transfer an individual with limited mobility) as needed.Record review of Resident #2's Physician Order reviewed on 01/29/2026 reflected the resident did not have an order for mechanical lift.3. Record review of Resident #3's Face Sheet, dated 01/30/2026, reflected an [AGE] year-old female, admitted [DATE], diagnoses included muscle weakness and lack of coordination.Record review of Resident #3's Comprehensive MDS Assessment, dated 01/02/2026, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment did not indicate the resident (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was using a mechanical lift.Record review of Resident #3's Comprehensive Care Plan, dated 01/07/2026, reflected the resident was at risk for falls related to muscle weakness and one of the interventions was to transfer with Hoyer lift to wheelchair.Record review of Resident #3's Physician Order reviewed on 01/29/2026 reflected the resident did not have an order for mechanical lift.During an interview on 01/31/2026 at 11:45 a.m., Resident #3 stated the staff transferred her using a machine. She said before lifting her up, the staff would hook the sling to the machine and then the machine would raise her from the bed to her wheelchair.During an observation on 01/31/2026 at 11:48 a.m., revealed CNA D and CNA E transferred Resident #3 using a mechanical lift. The CNAs placed the mechanical lift's sling under the resident, hooked the ends of the mechanical lift's sling to the Hoyer lift, and transferred the resident to her wheelchair.4. Record review of Resident #4's Face Sheet, dated 01/30/2026, reflected an [AGE] year-old male, admitted [DATE], diagnoses included muscle weakness, unsteadiness of feet, and lack of coordination.Record review of Resident #4's Comprehensive MDS Assessment, dated 12/10/2025, reflected the resident had severe (resident required significant assistance and support in daily life) impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment did not indicate the resident was using a mechanical lift.Record review of Resident #4's Comprehensive Care Plan, dated 10/15/2025, reflected the resident was at risk for falls and one of the interventions was the resident would be assisted with transfer. The Comprehensive Care Plan also reflected that the resident required varying levels of staff assistance for ADLs and one of the interventions was to use adaptive equipment (e.g., utensils, transfer aids, non-skid footwear) to enhance participation. The plan did not indicate what transfer aid to use.Record review of Resident #4's Physician Order reviewed on 01/30/2026 reflected the resident did not have an order for sit-to-stand.During an interview on 01/31/2026 at 10:28 a.m., Resident #4 stated if he remembered it right, he started using the sit-to-stand around October of 2025 because his legs were not that strong anymore.During an observation on 01/31/2026 at 10:31 a.m., CNA D and CNA E transferred Resident #4. The CNAs pushed the sit-to-stand machine inside the resident's room, put the waist strap around the resident's waist, hooked the waist strap to the hook of the sit-to-stand and transferred the resident to his wheelchair.5. Record review of Resident #5's Face Sheet, dated 01/30/2026, reflected a [AGE] year-old male, admitted [DATE], diagnoses included muscle weakness, lack of coordination, and repeated falls.Record review of Resident #5's Comprehensive MDS Assessment, dated 11/16/2025, reflected the resident had severe impairment in cognition with a BIMS score of 06. The Comprehensive MDS Assessment did not indicate the resident was using a mechanical lift.Record review of Resident #5's Comprehensive Care Plan, dated 11/19/2025, reflected the resident was not care planned for a Hoyer lift.Record review of Resident #5's Physician Order reviewed on 01/29/2026 reflected the resident did not have an order for sit-to-stand.6. Record review of Resident #6's Face Sheet, dated 01/30/2026, reflected an [AGE] year-old male, admitted [DATE], diagnosis included repeated fall.Record review of Resident #6's Comprehensive MDS Assessment, dated 11/12/2025, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment did not indicate the resident was using a mechanical lift.Record review of Resident #6's Comprehensive Care Plan, dated 11/19/2025, reflected the resident was not care planned for Hoyer lift.Record review of Resident #6's Physician Order reviewed on 01/29/2026 reflected the resident did not have an order for mechanical lift.7.Record review of Resident #7's Face Sheet, dated 01/30/2026, reflected a [AGE] year-old female, admitted [DATE], diagnoses included multiple sclerosis (a disease that causes breakdown of the protective covering of the nerves) and contracture (tightening or shortening of the muscles).Record review of Resident #7's Comprehensive MDS Assessment, dated 11/25/2025, reflected the resident had moderate impairment in (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognition with a BIMS score of 09. The Comprehensive MDS Assessment did not indicate the resident was using a mechanical lift.Record review of Resident #7's Comprehensive Care Plan, dated 12/09/2025, reflected the resident was at risk for falls and one of the interventions was the resident would be assisted with transfer. The Comprehensive Care Plan also reflected staff were to use adaptive equipment (e.g., utensils, transfer aids, non-skid footwear) to enhance participation for ADLs. The plan did not indicate what transfer aid to use.Record review of Resident #7's Physician Order reviewed on 01/30/2026 reflected the resident did not have an order for Hoyer lift.8. Record review of Resident #8's Face Sheet, dated 01/30/2026, reflected a [AGE] year-old male, admitted [DATE], diagnoses included muscle wasting and lack of coordination.Record review of Resident #8's Comprehensive MDS Assessment, dated 11/24/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment did not indicate the resident was using a mechanical lift.Record review of Resident #8's Comprehensive Care Plan, dated 12/09/2025, reflected the resident required varying levels of staff assistance for ADLs and one of the interventions was to use adaptive equipment (e.g., utensils, transfer aids, non-skid footwear) to enhance participation. The plan did not indicate what transfer aid to use.Record review of Resident #8's Physician Order reviewed on 01/29/2026 reflected the resident did not have an order for sit-to-stand.During an interview on 01/30/2026 at 7:27 a.m., the MDS Nurse stated she was the one doing the residents' MDSs. She said she was not able to code that Residents #1, #2, #3, #4, #5, #6, #7, and #8 were using mechanical lifts because she did not see the orders for mechanical lifts. She said the MDS was a tool to identify the needs of the residents with regards to their care. She said, in order to provide the appropriate care, the residents should be assessed thoroughly to provide the current status of the residents so they would be care planned accordingly. She said the MDS gave the overall picture of the resident, and it was like puzzle pieces that needed to be put together. She said the MDS was for reimbursement but also to assess the residents' needs. During an interview on 01/30/2026 at 7:44 a.m., the DON stated the resident's MDS should reflect their mode of transfer because sometimes the MDS was the basis of what should be included in the care plan. She said she already coordinated with the MDS Nurse to fix the issue.During an interview on 01/30/2026 at 10:26 a.m., the Administrator stated if the MDS Assessment needed to reflect that residents were using a mechanical lift, then the residents' MDS should display it. She said she knew the DON and the MDS Nurse already started fixing the issue.Record review of the facility policy, Comprehensive Assessment and the Care Delivery Process Nursing Services Policy and Procedure Manual for Long-Term Care revised December 2016 revealed Policy Statement: Comprehensive assessments will be conducted to assist in developing person-centered care plans . 2. Assessment and information . a. Assess the individual . (1) Gather relevant information from multiple sources . (a) Observation; (b) Physical assessment; (c) Symptom or condition-related assessments; (d) Resident and family interview . (h) Evaluations from other disciplines.

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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** Based on observation, 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 that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for six (Residents #1, #4, #5, #6, #7, and #8) of twenty-nine residents reviewed for care plans. The facility failed to ensure Residents #1, #4, #5, #6, #7, and #8 were care planned for the transfer mode used on 01/29/2026.This failure could place residents at risk of not receiving the necessary care needed during transfer. Findings included:Record review of Resident #1's Face Sheet, dated 01/29/2026, reflected a [AGE] year-old female, admitted [DATE], diagnoses included muscle weakness, unsteadiness of feet, lack of coordination, convulsion, and history of fall.Record review of Resident #1's Comprehensive MDS Assessment, dated 11/17/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment did not indicate the resident was using a mechanical lift.Record review of Resident #1's Comprehensive Care Plan, dated 11/23/2025, reflected the resident was at risk for fall related to unsteady gait, history of falls, muscle weakness, and cognitive impairment. The Comprehensive Care Plan also reflected, with revision date, 12/31/2025, staff were to use adaptive equipment (e.g., utensils, transfer aids, non-skid footwear) to enhance participation for ADLs. The plan did not indicate what transfer aid to use.Record review of Resident #1's Physician Order reviewed on 01/29/2026 reflected the resident did not have an order for sit-to-stand.During an interview on 01/29/2026 at 8:41 a.m., Resident #1 stated some staff would transfer her using a machine. She said she had been using the machine last year, but she could not remember the exact date.2. Record review of Resident #4's Face Sheet, dated 01/30/2026, reflected an [AGE] year-old male, admitted [DATE], diagnoses included muscle weakness, unsteadiness of feet, and lack of coordination.Record review of Resident #4's Comprehensive MDS Assessment, dated 12/10/2025, reflected the resident had severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment did not indicate the resident was using a mechanical lift.Record review of Resident #4's Comprehensive Care Plan, dated 10/15/2025, reflected the resident was at risk for fall and one of the interventions was the resident would be assisted with transfer. The Comprehensive Care Plan also reflected that the resident required varying levels of staff assistance for ADLs and one of the interventions was to use adaptive equipment (e.g., utensils, transfer aids, non-skid footwear) to enhance participation. The plan did not indicate what transfer aid to use.Record review of Resident #4's Physician Order reviewed on 01/30/2026 reflected the resident did not have an order for sit-to-stand.During an interview on 01/31/2026 at 10:28 a.m., Resident #4 stated if he remembered it right, he started using the sit-to-stand around October of last year because his legs were not that strong anymore.During an observation on 01/31/2026 at 10:31 a.m. revealed CNA D and CNA E were about to transfer Resident #4. The CNAs pushed the sit-to-stand machine inside the resident's room, put the waist strap around the resident's waist, hooked the waist strap to the hook of the sit-to-stand and transferred the resident to his wheelchair.3. Record review of Resident #5's Face Sheet, dated 01/30/2026, reflected a [AGE] year-old male, admitted [DATE]., diagnoses included muscle weakness, lack of coordination, and repeated falls.Record review of Resident #5's Comprehensive MDS Assessment, dated 11/16/2025, reflected the resident had severe impairment in cognition with a BIMS score of 06. The Comprehensive MDS Assessment did not indicate the resident was using a mechanical lift.Record review of Resident #5's Comprehensive Care Plan, dated 11/19/2025, reflected the resident was not care planned for (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hoyer lift.Record review of Resident #5's Physician Order reviewed on 01/29/2026 reflected the resident did not have an order for sit-to-stand.4. Record review of Resident #6's Face Sheet, dated 01/30/2026, reflected an [AGE] year-old male, admitted [DATE], diagnosis included repeated fall.Record review of Resident #6's Comprehensive MDS Assessment, dated 11/12/2025, reflected the resident was cognitively intact with a BIMS score of 13. The Comprehensive MDS Assessment did not indicate the resident was using a mechanical lift.Record review of Resident #6's Comprehensive Care Plan, dated 11/19/2025, reflected the resident was not care planned for Hoyer lift.Record review of Resident #6's Physician Order reviewed on 01/29/2026 reflected the resident did not have an order for Hoyer lift.5. Record review of Resident #7's Face Sheet, dated 01/30/2026, reflected a [AGE] year-old female, admitted [DATE], diagnoses included multiple sclerosis and contracture.Record review of Resident #7's Comprehensive MDS Assessment, dated 11/25/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 09. The Comprehensive MDS Assessment did not indicate the resident was using a mechanical lift.Record review of Resident #7's Comprehensive Care Plan, dated 12/09/2025, reflected the resident was at risk for fall and one of the interventions was the resident would be assisted with transfer. The Comprehensive Care Plan also reflected staff were to use adaptive equipment (e.g., utensils, transfer aids, non-skid footwear) to enhance participation for ADLs. The plan did not indicate what transfer aid to use.Record review of Resident #'7s Physician Order reviewed on 01/30/2026 reflected the resident did not have an order for mechanical lift.6. Record review of Resident #8's Face Sheet, dated 01/30/2026, reflected a [AGE] year-old male, admitted [DATE]., diagnoses included muscle wasting and lack of coordination.Record review of Resident #8's Comprehensive MDS Assessment, dated 11/24/2025, reflected the resident had moderate impairment in cognition with a BIMS score of 12. The Comprehensive MDS Assessment did not indicate the resident was using a mechanical lift.Record review of Resident #8's Comprehensive Care Plan, dated 12/09/2025, reflected the resident required varying levels of staff assistance for ADLs and one of the interventions was to use adaptive equipment (e.g., utensils, transfer aids, non-skid footwear) to enhance participation. The plan did not indicate what transfer aid to use.Record review of Resident #8's Physician Order reviewed on 01/29/2026 reflected the resident did not have an order for sit-to-stand.During an interview on 01/30/2026 at 7:27 a.m., the MDS Nurse stated she was responsible for the care plans. She said care plans should be in place so the staff knew the interventions and goals for the resident and would be consistent in terms of the care provided. She said if the residents were using a mechanical lift for transfer, then their care plan should reflect that. She said she was not able to do Resident #1's, #4's, #5's, #6's, #7's, and #8's care plan for transfer via mechanical lifts because the was no orders. She said they already made an audit of the care plans of the residents and updated them accordingly.During an interview on 01/30/2026 at 7:44 a.m., the DON stated every resident needed a comprehensive care plan to make sure the residents received the applicable and appropriate care needed. She said the care plan should be in place so that the staff providing care would be on the same page. She said the care plan was important because it reflected the resident's problem lists, goals, and interventions. She said they already updated the care plans of the residents using mechanical lifts and also put the physician orders for them. During an interview on 01/30/2026 at 10:26 a.m., the Administrator stated all the residents should have a care plan appropriate to their needs. She said without the care plan, the staff would not know the goals and the interventions needed by the residents. She said the DON and the MDS Nurse already put the care plans for the resident using mechanical lifts. She said the care plan should reflect the specific transfer need of the residents.Record review of the facility's policy title, Comprehensive Care Plans, dated revised 10/01/2025, reflected, Policy: It (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality . Policy Explanation and Compliance Guidelines . 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision and assistance to prevent accident hazards for one of ten residents (Resident #1) reviewed for accidents.The facility failed to ensure CNA A used a transfer aid when she transferred Resident #1 from her bed to wheelchair, which resulted in her falling and obtaining a fracture to her left hip.On 01/30/2026 at 2:00 pm, an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 01/31/2026, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.This failure could place residents at risk for serious injury, harm, impairment, or death.Findings included:Record review of Resident #1's Face Sheet, dated 01/29/2026, reflected the resident was a 78 -year-old female, admitted [DATE], diagnoses included muscle weakness, unsteadiness of feet, lack of coordination, convulsion (involuntary movement of the muscles), and history of fall.Record review of Resident #1's Quarterly MDS Assessment, dated 11/17/2025, reflected the resident had moderate (resident may need additional support and monitoring) impairment in cognition with a BIMS score of 12. Section GG - Functional Abilities reflected the resident required partial/moderate assistance for sit to stand and chair/bed-to-chair transfer. The resident was not coded for mechanical lift.Record review of Resident #1's Comprehensive Care Plan, dated 12/10/2025, reflected the resident was at risk for falls related to unsteady gait, history of falls, muscle weakness, and cognitive impairment and one of the interventions was the resident would be assisted with walking, transfers, or toileting as needed, based on the resident's current ability. The Comprehensive Care Plan did not specify the kind of transfer was required for Resident #1.Record review of Resident #1's Comprehensive Care Plan, dated 12/10/2025, reflected the resident had a diagnosis of osteoporosis (brittle bones), placing them at increased risk for bone fractures (broken bones), chronic pain, loss of mobility, and independence and one of the interventions was to provide assistance with transfers and ambulation as needed (e.g., supervision, limited assistance, extensive assistance). The Comprehensive Care Plan did not specify the kind of transfer required for Resident #1.Record review of Resident #1's Comprehensive Care Plan, dated 12/10/2025, reflected the resident required varying levels of staff assistance for ADLs . placing them at risk for decreased independence, impaired dignity, and functional decline and one of the interventions was use adaptive equipment (e.g., utensils, transfer aids, non-skid footwear) to enhance participation. The Comprehensive Care Plan did not specify the kind of transfer required for Resident #1.Record review of Resident #1's Physician Order reviewed on 01/29/2026 reflected no order on how the resident should be transferred.Record review of Resident #1's Nursing Progress Notes, dated 01/11/2026, reflected, CNA called @10:50 a.m. for nursing assistance . During the transfer attempted resident lost balance and landed on both knees while the upper body remained leaning on the bed . Resident c/o severe pain 10/10 to the left hip area. Resident requested to be transferred to . hospital. 911 was called, resident was transferred onto a stretcher and transported to the hospital with EMT for further evaluation. The Dr . and DON notified, Resident's daughter . notified as well.Record review of Resident #1's Nursing Progress Notes, dated August 2025 to January 2026, reflected that there was no documentation that the resident refused the sit-to-stand.Record review of Resident #1's Physician/Practitioner Progress Notes, dated 01/02/20206, reflected, Patient currently stable, will maintain on strict fall precaution . monitor closely.Record review of Resident #1's Fall Risk Assessment, dated 01/02/2026, reflected the resident was a high risk for falls with a score of 32.Record review of Resident #1's PT Therapy Progress Notes, dated (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	08/22/2025, reflected, Pt requires use of sit to stand (a mobility aid used to help an individual transition safely from sitting to standing). Has difficulty raising RLE during transfer. Precautions: Fall risk due to weakness and delays in righting responses, declines in safety awareness.Record review of Resident #1's PT Therapy Progress Notes, dated 09/09/2025, reflected, Pt has increased anxiety with all sit to stand activities . Precautions: Fall risk due to weakness and delays in righting responses (automatic responses that help maintain postural stability), declines in safety awareness.Record review of Resident #1's PT Therapy Progress Notes, dated 10/04/2025, reflected, Pt requires use of sit to stand machine majority of time . Precautions: Fall risk due to weakness and delays in righting responses, declines in safety awareness.Record review of Resident #1's Medical Records, dated 01/11/2026, reflected, Pre surgical diagnosis: Closed (broken bone that did not break through the skin) intertrochanteric (hip bones) fracture of the left hip . Post surgical diagnosis: Closed intertrochanteric fracture of the left hip.Record review of the in-service provided after the fall incident, dated 01/12/2026, reflected, Incidents and Accidents . Policy: It is the policy of this facility for staff to utilize Risk Management to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident . The purpose of incident reporting can include . Assuring that appropriate and immediate interventions are implemented and corrective actions are taken.Record review of the facility's in-service reviewed on 01/29/2026 reflected no in-service for safe transfer and handling during transfer of the residents was done after Resident #1 fell.During an interview on 01/29/2026 at 8:41 a.m., Resident #1 stated she fell a couple of weeks ago but was not sure of the exact date. She said she knew it was Sunday because she wanted to attend church that was why she asked to be changed and transferred to her wheelchair. She said after she was changed, the CNA put her wheelchair beside her bed and started to transfer her. She said she was not sure if her knees buckled or she felt dizzy and when she knew it she was kneeling on the floor. She said, at first, she did not feel any pain even when the staff sat her down on the floor but when they asked if she could be repositioned, that was when she felt severe pain on her hips. She said it happened so fast the CNA was not able to catch her. She said the aide did not use a transfer aid to transfer her. She said she requested to go to the hospital and had to have surgery.During an interview on 01/29/2026 at 8:47 a.m., Resident #1's roommate stated Resident #1 was sent to the hospital after she fell. She said the curtain was pulled and she really did not see what happened. She said all she knew was she was being transferred to her wheelchair and then all of a sudden there was a commotion.During an interview on 01/29/2026 at 9:18 a.m., CNA A stated Resident #1 fell on a Sunday, 01/11/2026. CNA A said RN B told her Resident #1 wanted to get up for church service and wanted to be cleaned and changed. She said after changing Resident #1, she got the wheelchair, placed it close to the bed, and started to transfer the resident. She said the resident said, give me your hand, so she extended her hand, and Resident #1 used it to help herself stand up. She said Resident #1 was heavy and her left leg was weak. She said she noticed the weak leg was not turning and moving. She said the resident tried to reach for the armrest of the wheelchair, became dizzy and fell knee first on the floor. CNA A said she screamed for help and RN B came to the room. She said while the resident was still kneeling on the floor, RN B assessed the resident and the resident said she was not in pain. She said RN B and herself tried to see if the resident could sit on the wheelchair, but it was hard because the resident's legs were weak. She said RN B kept on asking the resident if she was in pain while they were trying to reposition her. She said she went out of the room to call the Weekend Supervisor for assistance. She said RN B, the Weekend Supervisor, and herself carefully sat the resident on the floor. She said the resident did not complain of pain (continued on next page)

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	675151	A. Building B. Wing	01/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Care Center	632 Windsor Way Van Alstyne, TX 75495

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	when repositioned. She said they tried to reposition her again, that was when the resident complained of pain so they stopped and both RN B started to call and the Weekend Supervisor started making calls. She said the resident was a one-person assist for transfer and she should have used a gait belt for transfer, especially since she knew Resident #1 had weakness to one side. She said the gait belt was to secure the resident. She said Resident #1 would always say not to rush her because her left leg was weak. She said she never rush the resident.During a telephone interview on 01/29/2026 at 10:23 a.m., the Weekend Supervisor stated she did not witness the incident. She said RN B told her Resident #1 had fallen and they were not able to get her up. She said she went with RN B and saw Resident #1 sitting on the floor. She said she asked the resident if she was having any pain and Resident #1 denied pain. The Weekend Supervisor said she told Resident #1 they would attempt to reposition her because she was too close to the bed. The Weekend Supervisor said, at that point, Resident #1 said she was having pain in her left hip. She said they stopped and RN B called 911. She said she asked CNA A what happened and CNA A said she went to transfer the resident and one of the resident's knees gave out. She said she was not sure on Resident #1's mode of transfer but if she was a one-person assist, CNA A must use a gait belt to help transfer. She said the gait belt would provide an extra support because it would give CNA A something to hold on to. She said Resident #1 told her that at first she thought her knee popped when she fell.During a telephone interview on 01/29/2026 at 10:33 a.m., RN B stated she was making rounds when she heard CNA A calling for help from Resident #1's room. She said upon entering the room, she saw the resident kneeling on the floor beside her bed. She said she did not know exactly what time it happened nor what happened. She said she asked CNA A what happened and CNA A told her she thought the resident lost her balance. RN B said Resident #1 was heavy and she called the Weekend Supervisor for assistance. She said the three of them put the resident on the floor from the kneeling position. She said the resident was not complaining of any pain when she was lowered to the floor. She said the Weekend Supervisor assessed the resident and asked her if it was ok to get her up. She said, at that point, Resident #1 complained of pain scale of 10/10 in the hip area and requested to be sent to the hospital. She said she called 911 and then notified MD, DON, and responsible party. She said if CNA A used a gait belt, there would be a possibility the resident would not have fell on her knees. She said the DON told her to educate CNA A about safe transfers.During an interview on 01/29/2026 at 11:21 a.m., the DON stated the Weekend Supervisor called to let her know they called 911 for Resident #1. She said she was told that the resident fell when CNA A was transferring her. She said the resident had left leg pain but the Weekend Supervisor could not tell whether it was the knee or the hip. She said Resident #1was sent to the ER and that afternoon, they learned from the daughter of the resident, Resident #1 had a fracture that required surgery. She said Resident #1 had a rod inserted to her hip. She said RN B notified her Resident #1 had a fracture. The DON said she asked RN B to educate CNA A about transfers. She said she told RN B to make a statement about the incident. The DON said, prior to the 01/11/2026 incident, Resident #1 was a one person assist and staff were supposed to use a gait belt to have an extra level of support. She said since the resident had a diagnosis of weakness and unsteady gait, the staff should be more careful with transferring. She said she did an in-service about accidents and hazards but not about safe transfers. She said it did not know why she did not do an in-service about safe transfers. She said she was responsible in making sure that the residents were transferred safely and appropriately.During an interview on 01/29/2026 at 11:43 a.m., the Administrator stated she was notified of the incident after Resident #1 was already in the hospital. She said she was told she fell while attempting to transfer from chair to wheelchair. She said that her understanding was Resident #1 was (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	self-transferring, which was why it was reported to the state. She said later she learned Resident #1 fell during transfer. She said the DON did an in-service about accidents and hazards but did not in-service about safe transfers. She said CNA A should have used a gait belt when she transferred Resident #1.During an interview on 01/30/2026 at 6:30 a.m., CNA E stated she knew Resident #1 fell two Sundays ago because the resident told her. CNA E said Resident #1told her CNA A did not use a machine when she was transferred. She said prior to the fall incident, the resident's mode of transfer was the use of sit to stand. She said the resident did not refuse the use of sit-to-stand everytime she would use it to transfer her. She said when the resident was admitted , she was not walking and was already using the wheelchair. She said therapy worked with her and was able to take a few steps. CNA E said Resident #1 had weakness and was started on using a mechanical lift. She said all the aides knew about the resident's mode of transfer. She said they did not have an in-service about safe transfer when Resident #1 had a fall during transfer.During an interview on 01/30/2025 at 6:51 a.m., LVN S stated she knew Resident #1 fell and was sent out for further evaluation. She said she was told during shift report Resident #1 sustained a fractured o hip when she fell during a staff assisted transfer. LVN S said prior to incident, she was not sure if the resident was a sit to stand. She said CNA A should have used a gait belt for safety measures regardless if the resident could transfer by herself or not. She said, if Resident #1 used a mechanical shift, the CNA should have used the machine because there was a reason why she was ordered to do so. During an interview on 01/30/2026 at 7:27 a.m., the MDS Nurse stated when Resident #1 first came to the facility, she was on skilled nursing (a level of care designed for individuals with complex medication that needed a high level of care), and the mode of transfer was stand and pivot. She said before the fall, the mode of transfer was a sit to stand. She said she heard from their morning meeting, after the fall, that the resident's knees buckled and she went down to her knees. She said CNA A was transferring the resident when she fell on her knees. She said transfer aids could be in the form of gait belts and mechanical lifts.During an interview on 01/30/2026 at 7:44 a.m., the DON stated she knew there was a recommendation from therapy about changing Resident #1's mode of transfer from stand and pivot to sit-to-stand but did not know if there was a final decision about the matter and failed to follow up. she said, if she could remember it right, the recommendation was done during one of the departmental meetings but said she could not remember the exact date. She said when they interviewed CNA A, CNA A said she transferred the resident using her hands to guide the resident. She said the term transfer aids meant Hoyer lifts, sit-to-stands, and gait belts.During an interview on 01/30/2026 at 8:03 a.m., CNA D stated she knew that Resident #1 fell during a transfer. She said Resident #1 told her about the fall and according to the resident, CNA A was beside her but was not able to catch her. She said the resident's mode of transfer was sit-to-stand since around September of 2025. CNA D said she talked to therapy about the resident not moving during transfer and unable to turn. During an interview on 01/30/2026 at 8:23 a.m., Resident #1 stated that she must have misjudged how far she was from the bed or she sat down too soon and ended up on the floor, kneeling beside the bed. She said CNA A did not use a gait belt nor a machine. She said the other CNAs used a machine when they transferred her. She said, after the fall, she had pain where she did not have before. She said after the fall, her movements were limited and she became anxious when trying to move. She said she did not want to fall and had surgery but it happened. During a interview on 01/30/2026 at 8:42 a.m., the Weekend Supervisor stated she did not see a sit to stand machine when she entered Resident #1's room nor in the hallway. She said she was not aware that the resident's mode of transfer was sit to stand. She said whatever was the resident's mode of transfer, the staff should have used it to protect the resident. She (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	saidDuring an interview on 01/30/2026 at 8:58 a.m., the DOR stated Resident #1 was first admitted to the facility for skilled nursing. She said the resident was wheelchair bound during admission. She said before Resident #1 fell, her mode of transfer was the use of sit-to-stand machine due to weakness. The DOR said she gave the recommendation to the nursing department and, from there, she did not know how they transferred Resident #1. During a interview on 01/30/2026 at 9:21 a.m., RN B stated she was PRN and was not always in the facility. She said they usually use a gait belt to transfer Resident #1. She said she was sure CNA A did not use a gait belt because she saw the gait belt hanging on the wall when she entered the room. She said if the resident required sit-to-stand, then the machine should have been used. She said she did not see machine inside the room or in the hallway. During an interview on 01/30/2026 at 10:26 a.m., the Administrator stated she knew they talked about Resident #1's change in mode of transfer but did not know that it was implemented. She said the resident refused to transferred via sit-to-stand. The administrator said examples of transfer aids would be Hoyer lift, sit-to-stand, gait belts, and sliding board.During an interview on 01/30/2026 at 10:41 a.m., RN C stated she knew Resident #1 used a sit-to-stand because it was discussed during one of their morning meetings. She said the DON and the Administrator were always present during the morning meeting. She said she could remember the therapy department recommended sit-to-stand it was deemed that it would be safer for the resident. She said she knew about it and other nurses also knew about it. She said CNA A also knew that the resident was being transferred via sit-to-stand because she saw CNA A used the machine. She said Resident #1 did not refuse sit-to-stand.During an interview on 01/30/2026 at 11:09 a.m., the Social Worker stated she participated during the morning team meetings. She said she heard on one of their morning meetings, with the therapy department, about changing Resident #1's mode of transfer. She said she was not sure the exact date of the recommendation. She said it was also during their morning meeting that she heard about the fall during their meeting. During a telephone interview on 01/30/2026 at 11:27 am, CNA A stated she knew Resident #1 was a sit to stand before she fell. She said she used sit-to-stand on her when she was on the other hall but when she was transferred to the present room, she never used the sit-to-stand. She said she did not use the sit-to-stand on the day of the fall. CNA A did not reply when asked why she did not use the sit-to-stand.During a telephone interview on 01/30/2026 at 11:39 a.m., the NP T stated he documented on Resident #1's progress notes for strict fall precautions because of the resident's impaired balance. He said he was notified about the fall. He said some fall precautions included lowering the bed, place near the nurse's station, mat on the floor, and monitor medications.Record review of the facility's in-service, dated 01/12/2026, reflected an in-service about Incidents and Accidents. There was no in-service done for after the fall reflected no in-service for safe transfers and using appropriate transfer.This was determined to be an Immediate Jeopardy (IJ) on 01/30/2026 at 2:22 p.m the Administrator was notified. The Administrator was provided with the IJ template on 01/30/2026 at 2:26 p.m.The following Plan of Removal submitted by the facility was accepted on 01/31/2026 at 12:01 p.m.Facility: [Facility Name]Date: 01/30/2026Problem: F689 Accidents and Hazards Plan of RemovalOn 01/29/2026, an investigation survey was initiated at the facility. On 01/30/2026, the surveyor provided Immediate Jeopardy (IJ) for SNF notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. F-689- Free of Accident Hazards/Supervision/Assistive Devices (F689 - The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.1. Immediate Actions Taken for Those Residents IdentifiedAction: Resident #1 immediately evaluated by nursing staff. Care plan updated to reflect current transfer status. Resident requires a sit to stand lift. Order placed in the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	electronic medical administration record for mechanical lift transfers. Physical Therapy referral placed in the electronic medical administration record for evaluation and treatment. Person(s) Responsible: Director of Nursing (DON), Regional Nurse Consultant, and/or Designee Date: 01/30/2026 by 5 p.m. Action: All licensed nurses, CNAs, and therapy staff educated on Safe Resident Handling/Transfers policy. Staff members will be educated prior to working their next shift. Staff who are not present will receive education via the telephone prior to working their next shift. All new hires and agency staff will receive education before providing resident care. Person(s) Responsible: Director of Nursing (DON), Regional Nurse Consultant, and/or Designee Date: 01/31/2026 by noon Action: 1:1 education provided to Director of Nursing on following recommendation made by therapy on resident transfers and discussing those residents in clinical meeting Monday thru Friday and weekly during the center Standards of Care Meeting. Person(s) Responsible: Regional Nurse Consultant Date: 1/30/2026 by 10:00 p.m. 2. How the Facility Identified Other Possibly Affected Residents:Action: The DON and designee(s) reassessed all residents using the Fall Risk Assessment Tool and the MOS Nurse ensured all residents identified as at risk for falls had safety measures, as well as resident specific interventions, added to their care plans. Responsible Person(s): Director of Nursing (DON) and MOS Nurse Date: 1/31/2026 by noonAction: The MOS Nurse will ensure the safety measures and resident specific interventions that were added to the care plans were also reflected on the electronic and paper medical record so that the CNAs had access to this information. Responsible Person(s): MOS Nurse Date: 1/31/2026 by noon Action: The DON and designee(s) instructed the CNAs to review the updated paper medical record prior to their next shift. Responsible Person(s): Director of Nursing (DON), Regional Nurse Consultant, and/or MOS Nurse Date: 1/31/2026 by noon Action: 100% audit of all residents requiring assistance with transfers conducted to ensure accuracy of transfer status and updated care plans. Person(s) Responsible: Director of Nursing (DON), Regional Nurse Consultant, and/or Designee Date: 01/30/2026 by 10 p.m. Action: 100% audit of all therapy recommendations from August 1, 2025, to current reviewed and followed Person(s) Responsible: Director of Nursing (DON), Regional Nurse Consultant, and/or Designee Date: 01/31/2026 by noon 3. Measures that were put into Place/System Changes to remove the immediacy, and what date these actions occurred:Action: Policy on Safe Resident Handling/Transfers reviewed with no changes made. Staff members will be educated on policy prior to working their next shift. Staff who are not present will receive education via the telephone and will sign the in-service sheet prior to working their next shift. All new hires and agency staff will receive education prior to providing resident care. Person(s) Responsible: VP of Clinical Operations, Director of Nursing (DON), Regional Nurse Consultant, and/or Designee Date: 01/30/2026 at 3:30 p.m. policy reviewed with no changes made Action: The DON or designee will audit new admissions daily to ensure the Fall Risk Assessment Tool has been completed and that risk factors, safety measures, and resident specific interventions are reflected on the care plan as well as updated on the Kardex (gives a brief overview of each patient). Responsible Person(s): Director of Nursing (DON) Date: Ongoing x 60 daysAction: The Regional Nurse Consultant will review all falls within 72 hours for three months to ensure an RCA has been conducted and that resident specific interventions are reflected in the care plan as well as updated on the paper and electronic care plan chart Responsible Person(s): Regional Nurse Consultant Date: Ongoing x 60 days Action: The DON or designee will review all falls at the daily stand up meeting with the IDT for three months to ensure appropriate fall interventions are implemented, the resident's care plan has been reviewed and revised, and the Kardex has been updated. Responsible Person(s): Director of Nursing (DON) Date: Ongoing x 60 days Action: Interdisciplinary team will review all audit results in QAPI weekly for 8 weeks, then monthly for 4 months. Any identified trends (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	will result in additional training. Person(s) Responsible: Administrator, Director of Nursing (DON) and/or Rehab Director Date: Ongoing QAPI-Action: Medical Director notified of the deficient practice/IJ and Plan of Removal. Person(s) Responsible: DON, Administrator, and/or Designee Date: 01/30/2026Immediate Interventions:1. Resident #1 evaluated, care plan updated of the current transfer status, order and Physical Therapy placed in electronic medical record.2. All licensed nurses, CNAs, and therapy staff educated on Safe Resident Handling/Transfers policy. All new hires and agency staff will receive education before providing resident care.3. Director of Nursing in-serviced on following recommendation made by therapy on resident transfers and discussing those residents in clinical meeting.4. The Fall Risk Assessment of all the residents were re-assessed.5. Safety measures and resident specific interventions that were added to the care plans were also reflected on the paper and electronic medical record so that the CNAs had access to this information.6. The CNAs were instructed to review the updated paper medical record prior to their next shift.7. Audit of all residents requiring assistance with transfers conducted to ensure accuracy of transfer status and updated care plans.8. Audit of all therapy recommendations reviewed and followed.9. Audit new admissions daily to ensure the Fall Risk Assessment Tool has been completed and that risk factors, safety measures, and resident specific interventions11. All falls will reviewed within 72 hours to three months to ensure an RCA has been conducted.12. Interdisciplinary team will review all audit results in QAPI weekly for 8 weeks, then monthly for 4 months.Monitoring:1. On 01/30/2026, Resident #1's intervention updated and reflected the resident's current transfer status.2. On 01/30/2026, Resident #1's care plan reflected the resident's current transfer status.3. On 01/30/2026, Staff received an education pertaining to Safe Resident Handling/Transfer as evidenced by a signed Education Page with twenty-eight signatures. Fifteen staff were educated face-to-face while thirteen staff educated via phone call. The education was inclusive of all three shifts and various disciplines.4. Fall Prevention Program under Basic Restorative Skills included on the Nurse Aide Competency for new hires.5. The DON was in-serviced by RCN on 01/30/2026 about following recommendations done by the therapy department.6. Audit of fall risk assessment of all residents provided.7. Copy of paper Kardex provided.8. Transfer status of all residents provided.9. Audit of therapy recommendations provided.10. Copy of risk assessment for two new admission provided.11. Ad-Hoc QAPI sign-in, dated 01/30/2026, with nine signatures provided.Staff Monitoring:During an interview on 01/31/2026 at 12:36 p.m., LVN L she was in-serviced about transfers and safe handlings of the residents before she began her shift. She said the in-service talked about making sure the appropriate transfers needed by a specific resident.During an interview on 01/31/2026 at 1:10 p.m., CNA D stated she had an in-service about safe transfer and the use of the transfer aids like Hoyer lift, sit-to-stand, and gait belt. She said she was also provided a Kardex with an updated mode of transfer for all residents. She said she also had a check off about transfer.During an interview on 01/31/2026 at 1:20 p.m., CNA E stated the staff had an in-service about safe resident handling/transfer. She said residents whose mode of transfer were stand and pivot should use a gait belt. She said the DON provided the in-service and the DOR provided a visual education. She said the education included Hoyer lifts and sit-to-stand. She said she had a check-off on how to put on the gait belt, how to operate the Hoyer lift and sit-to-stand. She said she was also reminded to make sure that the machine were in good condition before using and to clean after using. During an interview on 01/31/2026 at 1:27 p.m., the DOR stated she conducted a training with the CNAs and Nurses about gait belts, Hoyer lifts, and sit-to-stand were given. She said she also provided visual education with the staff that were not present the night before. She said she also provided a virtual training with the therapists so they would be confident in case they would be transferring the (continued on next page)

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