| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675151 | A. Building<br>B. Wing | 05/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Meadowbrook Care Center | 632 Windsor Way<br>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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the residents' right to be free from physical abuse for 2 (Resident #1 and #2) of 4 residents reviewed for abuse. The facility failed to ensure Resident #2 was free from physical abuse when Resident #1 grabbed Resident #2's right arm during an altercation on 03/25/2026 at 12 p.m. in the doorway of Resident #1's room, where the residents' wheelchairs had become entangled. This failure could place residents at risk for emotional distress, fear and decreased quality of life.Findings included: Record review of Resident #1 face sheet dated 05/05/2026 indicated she was a [AGE] year-old female admitted on [DATE]. Her diagnosis included cerebral infarction (a stroke caused by a blockage in blood vessels supplying the brain due to lack of oxygen), depression, and hypertension (high blood pressure). Record review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS score of 12 indicating moderate cognitive impairment and had no physical or verbal behavioral symptoms. Record review of the care plan reviewed and updated on 12/31/2025 indicated Resident #1 had impaired cognition or thought processes related to difficulty in making decisions. The goal was she would maintain current level of cognitive function through the next review date. Interventions included communicating with resident/family regarding resident's capabilities and monitor/report to physician any changes in cognitive function. Record review of the Provider Investigation Report dated 04/01/2026 indicated an incident categorized as abuse occurred on 03/25/2026. The incident involved Resident # 1 in the doorway of her room where MA A witnessed Resident #1 grab Resident #2's right arm. An assessment was conducted on Resident #1 and there were no injuries, marks or bruises as a result of the incident. Resident # 1 was placed on 1 on 1 monitoring and a referral was made to psychiatric services. The administrator and an officer from the Van Alstyne police department interviewed Resident #1 on 03/25/2026 at 3:30 p.m. and according to her, Resident #2 propelled herself to the doorway of Resident #1 and attempted to enter her room. Resident #2 began yelling obscenities at Resident #1 and propelled herself towards the doorway. In an attempt to stop Resident #2 from entering the room, Resident #1 grabbed Resident #2's arm while arguing with her about entering the room. Subsequently their wheelchairs became entangled and the CMA came and separated them from each other. During an interview on 05/05/2026 at 1:22 p.m. Resident #1 stated she was doing fine and she did get upset with another resident who tried to come in her room and she didn't want her there. She stated she is not afraid of any residents and feels safe in the facility. In an interview on 05/05/2026 at 1:40 p.m. MA A stated she had not seen Resident #1 get upset or try to hurt another resident. She immediately separated them and took Resident #2 to DON's office to be assessed for injuries. Resident # 1 was put on 1:1. Record review of Resident #2's face sheet dated 05/05/2026 indicated she was an [AGE] year-old female who was admitted on [DATE]. Her diagnosis included Alzheimer's disease (a progressive brain disorder that slowly destroys memory and thinking skills), mood disorder (a condition characterized by persistent and intense emotional state that disrupts daily functioning), insomnia and high blood pressure. Record review of Resident #2's MDS dated [DATE] revealed a BIMS score of 10 indicating moderate cognitive impairment and had no verbal or physical behavioral symptoms noted. Record review of the<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | care plan initiated on 05/05/2026 indicated Resident #2 had a communication problem related to dementia that makes it difficult to express needs and understand others. The goal was she would use available methods to communicate her needs and participate in activities to the best of her ability with support from staff. Interventions included encourage to participate in activities to reduce isolation and staff will give her time to respond and avoid rushing when trying to communicate.<br>Record review of the Provider Investigation Report dated 04/01/2026 indicated an incident categorized as abuse occurred on 03/25/2026. After the incident occurred, the residents were immediately separated, a referral to psych services was made and Resident # 2 was moved to another room on the other side of the facility. A head-to-toe assessment was completed by the DON for Resident #2 and there were no injuries, marks or bruises that were sustained. The administrator and an officer from the Van Alstyne police department interviewed Resident #2 on 03/25/2026 at 3:40 p.m. She was happily sitting up in her bed watching TV. Due to her cognitive impairment, she was unable to articulate exactly what had transpired or who it transpired with. However, it appeared that Resident #2 was aware that an incident of some sort led to her being moved to another room. Resident #2 was not interviewed as she had been discharged to a memory care unit. In an interview on 05/05/2026 at 3:50 p.m. the DON stated that her expectation was if resident to resident abuse occurred, staff were to separate the residents, make sure both are safe and report it to the administrator. She stated the risk to the residents was the situation could further escalate. In an interview on 05/05/2026 at 3:55 p.m. the Administrator stated she expected the staff to separate the residents, closely supervise the aggressor and provide 1:1 and assess for injuries. She stated the risk to the residents if they were not separated was more harm or an increase in harm. Review of the policy Abuse, Neglect and Exploitation dated 09/01/2023 revealed the following, The facility will implement policies and procedures to prevent and prohibit all types of abuse, the identification, ongoing assessment, care planning for appropriate interventions and monitoring of residents with needs and behaviors which might lead to conflict or neglect. |