

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2025
NAME OF PROVIDER OR SUPPLIER Coryell Health Rehablving at the Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 110 Chicktown Rd Gatesville, TX 76528	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2025
NAME OF PROVIDER OR SUPPLIER Coryell Health Rehablving at the Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 110 Chicktown Rd Gatesville, TX 76528	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records review the facility failed to ensure that a resident receives treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, for one (Resident #1) of two residents reviewed for foot wounds. The facility's Agency CNA put tennis shoes on Resident #1 after being told not to put tennis shoes on Resident #1 who had a blister on the back of her left heel which later became a pressure ulcer. This failure could place residents at risk of discomfort and worsening of foot blister or wound. Review of Resident #1's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including Dementia with behavioral disturbance, DM w/o complication type II Anxiety, Chronic diastolic CHF (congestive heart failure- is a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply.) Chronic obstructive pulmonary disease (Chronic obstructive pulmonary disease (COPD) is an ongoing lung condition caused by damage to the lungs), Dependence on supplemental oxygen, Age related osteoporosis, Dementia without behavioral disturbance, Generalized muscle weakness, Abnormality of gait due to impairment of balance, Benign hypertensive heart disease with congestive heart failure, Sprain of unspecified ligament of left ankle, Unspecified fall, subsequent encounter. Review of Resident #1's quarterly MDS assessment, dated [DATE], reflected a BIMS score of 06, indicating severe cognitive impairment. Section I (Active diagnosis) reflected she had Chronic Pain. Section J (Health Conditions) reflected she had been hurting within the past five days and her pain intensity of 06 on the pain scale 00-10. Section M (Skin Condition) indicated the resident was at risk of developing pressure ulcer/ injuries. Review of Resident #1's quarterly care plan, initiated [DATE] and modified on [DATE], reflected she had blister at her left heel with interventions to off load her heels with a cushion or pillow to prevent skin breakdown on her heels, change dressings as ordered. The care plan also reflected Resident #1 had LTC Pain IPOC, with outcome of pain level maintained at less than moderate. Review of the facility's wounds documentation reflected Resident #1's left heel skin issue was identified on [DATE]. Review of Resident #1's wound notes dated [DATE] completed by the Wound Care Nurse reflected: Type of Injury/ Onset: Pressure ulcer DTILocation of Wound: L HEELWound Dimension:Length: 2.5 cm Width 2.4cm Depth: cmWound Appearance: Tissue Type (estimate%) 15 % Epithelial (the epithelial tissue, primarily the epidermis, that regenerates to cover a wound surface) 75 % Granulation (a type of new, pink, soft tissue that forms in the wound bed during the healing process) 10 % Slough (the dead, yellowish, or whitish tissue in a wound that can delay healing) % Necrotic Color (refers to the appearance of dead tissue, which is typically brown, gray, or black): pink Review of the facility's grievances revealed a grievance filed by Resident #1's family dated [DATE] and taken by the Administrator which reflected: During the course of last 60 days, a tissue injury was identified on resident's heel. Tennis shoes were not to be worn, and when [Resident #1's] family arrived, she had tennis shoes on. She feels like the communication between nursing administration and line staff should improve. She provided photos of the heel injury. Treatment in place and hospice is aware. What Action Was Taken: Daily document of [Resident #1] dx and what is going on with her on 24-hour report. Set up a care plan meeting with and hospice to ensure we are all on the same page Administrator will attend care plan meeting. Resolved by the Administrator on [DATE] Review of Resident #1's physician's order dated [DATE] reflected: WOUND CARE NURSE TO CHANGE DRSG TO LEFT HEEL ON MON & WED & FRIDAY/ BLISTER/DTI -ON MEDIAL LEFT HEEL/ CLEAN WITH VASHE/ APPLY BETADINE TO HEEL-ALLOW TO DRY/ APPLY ADAPTIC TO AREA/THEN COVER WITH TETRA NET ELASTIC DRSG / PLEASE DATE & INITIAL DRSG. USE HEEL BOOT AT ALL TIMES TO OFFLOAD PRESSURE/ USE LIDOCAINE SPRAY PRIOR TO WOUND CARE TO HELP CONTROL PAIN. Review of Resident #1's progress notes dated [DATE] reflected Resident #1 expired on [DATE]. During an interview on [DATE] at 3:00 pm Resident #1's family stated a fluid filled blister was identified on Resident #1's left heel sometimes in April of 2025. Resident #1's family stated Resident #1 was noted with tennis shoes on after it was communicated with the ADON that Resident #1 didn't need the tennis shoes due to the pressure area on Resident #1's heel. Resident #1's family stated she spoke with LVN A who stated Resident #1 was not supposed to be wearing tennis shoes. Resident #1's family stated she spoke with the CNA on duty that day and the CNA stated she did not know Resident #1 was not supposed to wear the tennis shoes. Resident #1's family stated she took the tennis shoes home. During an interview on [DATE] at 12:09 pm the Wound Care Nurse stated Resident #1 had a pressure area to her left heel which</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2025
NAME OF PROVIDER OR SUPPLIER Coryell Health Rehabliving at the Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 110 Chicktown Rd Gatesville, TX 76528	

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2025
NAME OF PROVIDER OR SUPPLIER Coryell Health Rehablving at the Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 110 Chicktown Rd Gatesville, TX 76528	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #1) of three residents reviewed for pain. The facility failed to assess Resident #1 pain level on [DATE] when family reported Resident #1 was hurting and needed pain medication. These failures could place residents at risk of increased pain, hospitalization, and a decreased quality of life. Findings included: Review of Resident #1's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including Dementia with behavioral disturbance, DM w/o complication type II, Anxiety, Chronic diastolic CHF (congestive heart failure- is a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply.), Chronic obstructive pulmonary disease (Chronic obstructive pulmonary disease (COPD) is an ongoing lung condition caused by damage to the lungs), Dependence on supplemental oxygen, Age related osteoporosis, Dementia without behavioral disturbance, Generalized muscle weakness, Abnormality of gait due to impairment of balance, Benign hypertensive heart disease with congestive heart failure, Sprain of unspecified ligament of left ankle, Unspecified fall, subsequent encounter. Review of Resident #1's quarterly MDS assessment, dated [DATE], reflected a BIMS score of 06, indicating severe cognitive impairment. Section I (Active diagnosis) reflected she had Chronic Pain. Section J (Health Conditions) reflected she had been hurting within the past five days and her pain intensity of 06 on the pain scale 00-10. (0 meaning no pain and 10 meaning worst pain) Section M (Skin Condition) indicated the resident was at risk of developing pressure ulcer/ injuries. Review of Resident #1's quarterly care plan, initiated [DATE] and modified on [DATE], reflected she had a blister on her left heel with interventions to Off load heels with cushion or pillow to prevent skin breakdown on heels, change dressings as ordered. Care plan also reflected Resident #1 had LTC Pain IPOC, with outcome of Pain Level Maintained at Less Than Moderate. Review of Resident #1's physician's orders reflected the following:Hydromorphone 1.5 mg, Oral, Liquid, every 1 hr, PRN pain, First Dose: [DATE] 12:42:00 CDT, Routine Give 1.5 ml = 1.5 mg every one (1) hours as neededFentanyl 12 mcg, Transdermal, every 72 hr, First Dose: [DATE] 6:00 pm RoutineHydromorphone-- 2 mg, Oral, Tab, QID, First Dose: [DATE] 4:00 pm Routine Per HospiceAcetaminophen 650 mg, Oral, Tab, every 4 hr, PRN fever, First Dose: [DATE] 1:26 pm Routine Give TWO (2) tablets of 325 to equal 650 mg total dose for fever Review of Resident #1's narcotic count sheet dated [DATE] reflected Resident #1 was given Hydromorphone 2 mg 2 tabs at 7:31 pm by LVN A. Review of Resident # 1's narcotic count sheet dated [DATE] reflected Resident #1 was given Hydromorphone 5mg/5ml solution at about 8:00 pm by LVN A for break through pain. During an interview on [DATE] at 3:00 pm, Resident #1's family stated Resident #1 was crying of pain at about 6:30 pm on [DATE] and the nurse stated the resident had just gotten her 6:00 pm medication and could not get pain medication until 7:00 pm. Review of Resident #1's pain assessment on [DATE] reflected the following:No actual or suspected pain (Charted at [DATE] 10:46pm)No actual or suspected pain (Charted at [DATE] 11 :42 am)There was no pain assessment noted on [DATE] at about 6:30 to 7:30 pm when Resident #1's family requested pain medication. Review of Resident #1's progress notes dated [DATE] reflected Resident #1 expired on [DATE]. During an interview on [DATE] at 09:04 am LVN A stated, she was not sure of the date but there was a day Resident #1's family requested pain medication, and she told Resident #1's family that Resident #1 had just gotten pain medication at 6:00 pm. LVN A stated Resident #1's family stated Resident #1 did not get pain medication at 6:00 pm. LVN A stated she called the medication aide to confirm, and the medication aide stated she did not give Resident #1 pain medication at 6:00 pm. LVN A stated she gave Resident #1 her pain medication within the time frame, which was an hour before or an hour after. LVN A stated she would have given Resident #1 PRN pain medication as ordered but she was out of the time frame for medication administration. LVN A stated it depends on the day, some days Resident #1's was in so much pain and on other days she was not in pain. LVN A could say how much pain Resident #1 was in on [DATE]. During an interview on [DATE] at 1:55 pm the DON stated if a resident was complaining of pain, it was the expectation of the nurse to assess the resident's pain level. The DON stated not assessing the resident's pain level, they wouldn't be able to know what medication to give the resident or how to treat them. The DON reviewed Resident #1's MAR and TAR for [DATE] and stated Resident #1 was supposed to be assessed for</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2025
NAME OF PROVIDER OR SUPPLIER Coryell Health Rehabliving at the Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 110 Chicktown Rd Gatesville, TX 76528	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2025
NAME OF PROVIDER OR SUPPLIER Coryell Health Rehablving at the Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 110 Chicktown Rd Gatesville, TX 76528	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for one (Resident #1) of three residents review for medication administration. The facility failed to administer Resident 1's antibiotic on [DATE] as was ordered on [DATE]. This failure could place residents at risk of ineffective therapeutic effect. Findings included: Review of Resident #1's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including Dementia with behavioral disturbance, DM w/o complication type II, Anxiety, Chronic diastolic CHF (congestive heart failure- is a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply.), Chronic obstructive pulmonary disease (Chronic obstructive pulmonary disease (COPD) is an ongoing lung condition caused by damage to the lungs), Dependence on supplemental oxygen, Age related osteoporosis, Dementia without behavioral disturbance, Generalized muscle weakness, Abnormality of gait due to impairment of balance, Benign hypertensive heart disease with congestive heart failure, Sprain of unspecified ligament of left ankle, Unspecified fall, subsequent encounter. Review of Resident #1's quarterly MDS assessment, dated [DATE], reflected a BIMS score of 06, indicating severe cognitive impairment. Section I (Active diagnosis) reflected she had Chronic Pain. Section J (Health Conditions) reflected she had been hurting within the past five days and her pain intensity of 06 on the pain scale 00-10. Section M (Skin Condition) indicated the resident was at risk of developing pressure ulcer/ injuries. Review of Resident #1's physician's order dated [DATE] reflected: Cephalexin 500 mg. Oral, cap, every 12 hr (sch), Antibiotic Indication Urinary Tract Infection, first Dose: [DATE] 8:00 pm, Stop Date: [DATE] 7:59 PM, Physician Stop, Routine -do NOT crush or chew Review of Resident #1's Medication Administration Records (MAR) for the month of [DATE] reflected Resident #1's Cephalexin 500 mg. Oral, cap, every 12 hr (sch), was not given on [DATE]. Review of Resident #1's MAR for the month of [DATE] reflected Resident #1's Cephalexin 500 mg. Oral, cap, every 12 hr (sch), was given as followed: On [DATE] at 8:00 pm On [DATE] at 1:32 pm and at 7:48 pm. On [DATE] at 7:59 am and at 7:24 pm. On [DATE] at 7:51 am and at 7:06 pm On [DATE] at 8:26 am and at 7:10 pm On [DATE] at 8:36 am and at 7:01 pm Review of Resident #1's progress notes for [DATE] and [DATE] reflected no documentation of Resident #1 starting an antibiotic on [DATE] or why the ABT was not given on [DATE]. Review of Resident #1's progress notes dated [DATE] written by LVN A reflected: Resident is Day 1 of 7 for start of medication: Keflex for cystitis (is a medical condition that refers to inflammation of the bladder. It is a common infection of the urinary tract, typically caused by bacteria.) Adverse reaction / Side effects: no. If yes, document adverse reaction / side effects below: Medication appears to be_, If ineffective, has PCP been notified To early to see effects resident has only had 2 doses Electronically Signed on [DATE] 01:34 pm. Review of Resident #1's progress notes dated [DATE] reflected Resident #1 expired on [DATE]. During an interview on [DATE] at 2:28 pm, the Hospice Nurse stated she was not aware of Resident #1's ABT not being in the facility or not arriving on time. The Hospice Nurse stated the facility staff were good at communicating with hospice that the medication was not in the E-kit. The Hospice Nurse stated if it was communicated with hospice that Resident #1's ABT was not available, she would have ordered the medication from the nearby pharmacy or ordered the medication to start the following day. During an interview on [DATE] at 3:00 pm Resident #1's family stated on [DATE] Resident #1 was smelling of a foul urine odor. Resident #1's family stated hospice was contacted and an ABT was ordered. Resident #1's family stated hospice confirmed the ABT was ordered, and Resident #1 was starting the ABT on [DATE]. Resident #1 family stated she called on [DATE] and spoke with LVN A and asked about Resident #1's ABT administration. Resident #1's family stated she was told by LVN A that Resident #1 did not get her morning and evening dose of ABT due to the medication not being put in the system. Resident #1's family stated LVN A stated she would put the orders in the computer system. Resident #1's family stated she did not complain to hospice, the DON, ADON or the Administrator because she couldn't process what to say. During an interview on [DATE] at 09:04 am, LVN A stated she couldn't remember the exact incident regarding Resident #1's ABT orders because it has been a while. LVN A stated they may have started Resident #1's ABT the next day or so. LVN A stated it might have been pharmacy issues. LVN A stated they could take the ABT from the e-kit, but there were lot of residents in the facility who also got medication from the e-kit and staff had to wait for the medication to be refilled in the e-kit During an</p>		