STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Meridian	2228 Seawall Blvd Galveston, TX 77550

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 0640

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 26867

39977

Based on interviews and record review, the facility failed to ensure resident assessments were electronically transmitted with MDS data to the CMS System for discharge return not anticipated for 2 of 32 residents (CR #1 & 58) reviewed for encoding and transmitting resident assessments.

- The facility failed to submit/transmit/export a Return Not Anticipated MDS for CR #1- within the required timeframe.

- The facility failed to submit/transmit/export a Return Not Anticipated MDS for CR #58 within the required timeframe.

This failure could place discharged residents at risk of not receiving proper Medicaid benefits after discharge and of not having their assessments transmitted/exported timely.

Findings included:

-CR #1

Record review of CR # 1's face sheet dated 10/30/24 revealed an 81-year -old female admitted to the facility on [DATE]. Her diagnoses included anemia (low red blood count), hypothyroidism (a disorder of the endocrine system in which the thyroid gland does not produce enough thyroid hormones), heart disease, and lower back pain.

Record review of CR #1's clinical records nurse's note dated 11/29/2023 15:48 read in part: Resident was brought to nurse's station by PTA staff. Large edematous hematoma to RLE. Measures 8.3 cm x 4.6 cm. Staff explained res hit her leg-on-leg rest during transfer to wheelchair. RLE elevated and ice pack applied to site. Res did complain of pain 8 out of 10- and one-time order for Tylenol #4 obtained and administered. Son notified via voicemail of incident. Will continue to monitor for changes. Record review of emergency transfer note indicated CR #1 was sent to the hospital due to uncontrolled pain.

Record review of CR#1's discharge MDS with ARD date 11/29/23 coded as returned not anticipated was completed and transmitted on 07/03/24.

(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: 676260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER The Meridian		STREET ADDRESS, CITY, STATE, ZIP CODE 2228 Seawall Blvd Galveston, TX 77550	

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CR# 58' -Record review of CR# 58's admission record dated 10/30/2024 revealed she was a [AGE] year-old female who admitted to the facility on [DATE] with the following diagnoses: chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), insomnia (persistent problems falling and staying asleep), depression (a common mental disorder that involves depressed mood or loss of pleasure in activities for long periods of time), fracture (break) of unspecified part of neck of left femur (thighbone), and subsequent encounter for closed fracture with routine healing and pain in left hip. She discharged from the facility AMA (against medical advice) on 05/19/2024. Record review of CR #58's Admission MDS assessment dated [DATE], revealed she had a BIMS score of 15 out of 15 which indicated she had no cognitive impairment. She required set-up assistance with eating and oral hygiene. She required moderate assistance with most other ADLs (Activities of Daily Living). Record review of CR#58's Release of Responsibility for Discharge Against Medical Advice, dated 5/19/24 at 2:20 pm revealed CR#58 signed the document on 5/19/24 and it was witnessed by CR#58's family member and RN C. Record review of CR 58's nursing clinical progress note dated 05/15/2024 at 5:34pm revealed, Progress Notes: Res was persistent about wanting to discharge home d/t husband being discharged from Hospital A. Res explained husband (sic) has terminal leukemia and only had a few weeks to live. Dr. A saw resident during rounds and resident reported to Dr. A that she had a cousin who would be able to stay and assist with care. Staff were preparing to discharge resident when Death Doula, arrived (sic) to facility, and asked to speak with ADON. The Death Doula explained her role was to stay with the family until CR #58's husband passed away. However, the Death Doula refused to stay with the family d/t the house being uninhabitable when the Death Doula explained the circumstances, CR #58 became irate and began cussing and throwing things around the room. Demanded that she was leaving the facility . Record review of CR 58's EMR on 10/30/2024 revealed her Discharge Return Not Anticipated was dated as completed on 5/19/24 and was highlighted in red under the submission tab with the date 10/29/2024. Interview and observation with MDS A at 12:45 PM on 10/30/24 he said that CR#58's MDS Discharge Return not anticipated MDS dated [DATE] was no completed until 10/29/24. MDS A said that the highlighted date in red meant that the assessment was submitted late. MDS A said there had been no full time MDS Coordinator at the facility since June/July of 2023 when he went down to 3 days per week. MDS A said he just missed the dates and submitted the assessment for CR#58 late. MDS A said that he just failed to get it completed within the 7-14-day timeframe and the facility only recently hired a full time MDS Coordinator, MDS B, about 2 weeks ago. MDS A said that CR#58 could have negative payment or reimbursement issues because of the late Discharge Return Not Anticipated MDS Submission. MDS A said he used the RAI manual as his policy and procedure for the completion and submission of the MDS. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676260	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Meridian	2228 Seawall Blvd Galveston, TX 77550

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON at 12:12 pm on 10/30/2024 she said that she did not sign any facility MDS'. She said the ADON did. She said that MDS A was responsible for the completion, accurate and timely submission of MDS assessments. The DON said she was not sure when the new full time MDS B started and that she really did not know much about any of the MDS information or assessments . In an interview with the Administrator at 1:23 pm on 10/30/24 he said that he was aware that there were issues with the MDS department. He said they had hired another part-time MDS person, but they did not work out. The Administrator said there was an audit tool in PCC (EMR) that he would and could review but did not recall how frequently he had done that. The Administrator said from that report he could see which assessments were late. The Administrator said he started working at the facility in June 2024 and identified that the MDS department needed a full-time MDS Coordinator, and the facility had just hired one about 2 weeks ago . In an interview with the ADON at 1:31 pm on 10/30/24 shesaid she had worked at the facility for 3 years. The ADON said she was the only RUG certified RN in the building. She said she signed the MDS' but only signed that they were completed not for accuracy, or submission. She said she did check to see if assessments were completed on time and caught a few that had not been completed on time but could not recall any specific resident or assessment. The ADON said there had been no full time MDS Coordinator since last year, 2023. She said there was a large corporate level shift and some staff turnover. She said that the DON and the Admin were responsible for MDS oversight but in her opinion the Corporate MDS A was ultimately responsible and should oversee the facility assessments. The ADON said that possible adverse consequences for late submission of assessments could be financial for CR #58 and that CMS could take money back from the the facility. She said Corporate Nurse A trained her on completing MDS assessments but was no longer with the company. During a follow up interview with the Administrator at 4:42 pm on 10/30/24 he said that a possible negative or adverse effect for a resident with an incomplete, inaccurate, or late submission MDS assessment could be that the resident could run into problems with state reimbursement being affected, issues with qualifying stays, and that it could be a multitude of problems. Record review of CMS's RAI Version 3.0 Manual dated October 2023, Chapter 2; 2-37 revealed the following: 09. Discharge Assessment-Return Not Anticipated Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days. o Must be submitted within 14 days after the MDS completion date +14 days.

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NAME OF PROVIDER OR SUPPLIER The Meridian		STREET ADDRESS, CITY, STATE, ZIP CODE 2228 Seawall Blvd Galveston, TX 77550	

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26867 Based on observations, interviews, and record review, the facility failed to ensure that each resident received an accurate assessment, reflective of the resident's status at the time of the assessment, for ---2 of 16 (Resident #19 and #47) residents reviewed for MDS accuracy. -Resident #19 was not assessed for her lack of natural teeth on her oral cavity. -Resident #47's Admission assessment did not reflect his cognition and his lack of natural teeth on his oral cavity. These failures could place residents at risk for not receiving care and services to meet their needs, for diminished function of health, and for regressions in their overall health. Findings included: - Resident #19: Record review of Resident #19's face sheet dated 10/29/24 revealed a 73-year -old female admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included hypokalemia (low blood potassium levels), anxiety, heart disease, osteoarthritis (condition that causes the breakdown of cartilage in the joints, leading to pain and stiffness), weakness, anemia (low red blood count), and essential hypertension (high blood pressure). Record review of Resident #19's annual MDS dated [DATE] revealed Resident #19 had a BIMS score of 15 out of 15 which indicated she was cognitively intact. Record review of section L of the MDS oral dental section was coded 0 which indicated she has all her natural teeth with no difficulty. Observation and interview on 10/28/24 at 9:15 am, revealed Resident # 19 was in her room alert and oriented. During an interview she said she had her dentures, but she did not use them because they don't fit and were very painful. She pointed to her dentures and said they were in that white cup. She said she had told someone but does not remember who she spoke to. During an interview with the MDS coordinator on 10/29/24 at 12:20pm, he said he was not responsible for section L of the MDS. He said that was done by the Dietary Manager. Resident #47 -Record review of Resident #47's Face Sheet, dated 10/30/2024, reflected the resident was an [AGE] year-old male admitted on [DATE]. Resident #47's diagnoses included essential hypertension (high blood pressure, hypothyroidism (condition when the thyroid gland doesn't make enough thyroid hormone),. Cerebral infarction (a condition where there is a decrease flow of blood to the brain), chronic obstructive, and pulmonary disease (a type of progressive lung disease, convulsions). Review of Resident #47's Comprehensive MDS Assessment, dated 12/07/23 reflected Resident #47 had severe impairment in cognition with a BIMS score of 99. Record review of section L-oral dental section was coded as 0 which indicated he had all his natural teeth with no problem on his oral cavity. (continued on next page)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview, on 10/28/24 at 10:40AM, revealed Resident #47 was in his room with a bag of chips in his hand, he was alert and oriented during an interview, and he said that was his snack. Observation indicated he had no teeth in his oral cavity. He said he lost his dentures and doid with what he could. He said he was not sure where he lost them between seizures, hospital, and the facility. He asked if someone could help him to get them back. He said he ate mostly soft food, but he surely missed his dentures. During an interview with CNA E on 10/29/24 at 12:30PM, CNA E said she regularly worked with Resident # 47. She said Resident #47 was always awake, alert, and oriented X3, enough to answer questions, and did not seem to be cognitively impaired. CNA E said for most ADL care including oral care, she was able to provide set-up assistance for the resident and had no knowledge of his denture status. During an interview with the DON on 10/29/24 at 1:15 PM she said she had been communicating with Resident #47 without a problem since his admission. She said the Dietary Manager was responsible for doing section L of the MDS (oral cavity). She said the social worker was responsible for doing section B (Hearing, Speech, and Vision) and section C (Cognitive patterns) of the MDS. She said the facility had an audit on the MDS assessment and was aware of the corrections the process of making sure that all MDS accurately reflected resident's condition. She said the facility had just hired a new social worker that started this week (10/21/21). During an interview with the Dietary Manager on 10/30/24 at 3:00PM, she said she was responsible for section L of the MDS. She said she was told to ask residents if they had any problems eating and swallowing. She said she would code the MDS according to their answer. She said she did not understand how to code the MDS but was only doing what she was asked to do by a staff that no longer worked at the facility. Record review of facility's policy on Resident assessment dated 2001, revised 2022, titled Policy Statement: did not address accuracy of MDS assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26244 Based on observations, interviews and record reviews the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 1 of 16 resident reviewed for care plan accuracy (Resident # 27). --Resident # 27's care plan was not revised to reflect a healed deep tissue injury. This failure placed residents at risk of not receiving care according to their individual needs. Findings include: Record review of Resident # 27's face sheet revealed a [AGE] year-old male with admitted [DATE] and diagnoses including Diabetes (too much sugar in the blood), hypertension (high blood pressure), heart disease (conditions affecting the heart), hemiplegia and hemiparesis following a stroke (partial or complete paralysis affecting one side of the body), muscle weakness, reduced mobility, chronic kidney disease (longstanding kidney disease leading to kidney failure). . Record review of the annual MDS dated [DATE] revealed Resident #27 had a BIMS score of 07 indicating moderately impaired cognitive skills, always incontinent of bowel and bladder, and required maximum staff assistance for hygiene, dressing, bathing, and toileting, and dependent on staff assistance for transfers. Record review of wound evaluation from wound care Doctor dated 9/18/24 revealed unstageable DTI of right first toe (resolved 9/18/24), epithelialized and resolved. Record review of Resident # 27's care plan, undated, revealed I have an unstageable DTI of my right big toe, wound treatment as ordered. Interventions included: discontinue this care plan when problem was resolved. Observation and interview with Resident # 27 on 10/28/24 at 10:30am revealed he was resting in bed and said he did not have any wound on his toe. He said they used to treat it but the last time the wound care doctor looked at it, it was healed. Interview on 10/30/24 at 10:45am, LVN L said there were no skin issues with Resident # 27. Interview on 10/30/24 at 10:48 am, MDS A and B said there should not be a care plan for a wound if it was healed. MDS B assessed Resident #27 and said there was no wound on his right front toe, and the care plan would be revised. In further interview, they said the risk of having inaccurate care plans would be the resident not getting the right care according to their individual assessment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/30/24 at 11:40 am, the DON said the care plan should be accurate and match the resident. She said the former MDS nurse left, and a full-time MDS nurse started here 2 -3 months ago, which would help them get caught up with correct assessments. She said the risk to residents of inaccurate assessments would be they would not be getting proper care. Record review of the facility policy Comprehensive Resident-Centered Care Plans, revised March 2022, read, in part: assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change .the interdisciplinary team reviews and updates the care plan .

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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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50973 Based on record review and interviews, the facility failed to ensure completion of a discharge summary including a recapitulation of the resident's stay, final status at discharge and a reconciliation of medications for 1 resident of 1 resident (CR #64) reviewed for discharge summary. The closed record for Resident #64 that was reviewed did not contain a discharge summary that included a recapitulation of the resident's stay. This failure could place residents at risk of not receiving needed care and services after discharge. Findings included: The closed record face sheet for Resident #64 revealed an admitted [DATE] with diagnoses that included unspecified fracture of left femur, presence of left artificial hip joint, hypertension (a condition in which the force of the blood against the artery wall is too high), and hyperlipidemia (excess lipids or fat in the blood). Interview with admission's director on 10/29/2024 at 2:35 PM stated that they could not get in contact with the resident, but the resident's brother stated the resident was not coming back to the facility and if he needed to signto sign anything, it needed to be mailed. Interview with DON on 10/29/2024 at 3:40 PM stated they did not receive any notes from the doctor, and they did not mail out an AMA form for the patient to sign. The DON stated that everyone should have a discharge summary, and nothing was mailed out to the resident. The DON stated that the social worker was responsible for the discharge paperwork and mailing out discharge and AMA forms. Interview with the social worker on 10/30/2024 at 12:17 PM stated that the social worker was responsible for discharge planning, mailing discharge, and AMA forms but was not working during the time the resident was at the facility. The social worker stated that a discharge summary and AMA form should have been mailed to the resident. Record review of the facility's policy titled, Discharge Summary and Plan, dated revised October 2022, read in part that .when a resident's discharge is anticipated, a discharge summary and post-discharge plan is developed to assist the resident with discharge. The resident/representative is involved in the post-discharge planning process and informed of the final post-discharge plan.

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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 0757

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident's drug regimen must be free from unnecessary drugs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 26867

Based on observations, record review, and interviews, the facility failed to ensure each resident's drug regimen was free from unnecessary medications for 1 of 9 residents (Resident #38) reviewed for unnecessary medications. in that:

-The facility failed to ensure Resident that Resident #38 did not have an appropriate diagnosis associated with the use of Abilifya and his clinical record did not contain a diagnosis beyond the diagnosis on the consent which was identified as psychotic behavior.

This failure could place residents at risk for adverse drug reactions (unintended, harmful events attributed to the use of medicines) and receiving unnecessary medications.

Findings included:

Record review of Resident #38's face sheet dared 10/30/24 revealed a 72- year-old female admitted on to the facility on [DATE]. Her diagnoses included essential hypertension (high blood pressure, hypothyroidism (condition when the thyroid gland doesn't make enough thyroid hormone), alcohol dependence, Alzheimer's disease, and depression.

Record review of Resident #38's Admission MDS assessment dated [DATE] indicated Resident #38 had a BIMS score of 11 out of 15 which indicated moderate impairment on cognition.

Record review of Resident #38's physician orders and medication administration revealed Resident # 38 was on the following medications:

-Amlodipine Besylate Tablet 10 MG- Give 1 tablet by mouth one time a day for HTN start date 09/13/2024.

-Aricept Tablet 5 MG (Donepezil HCl) Give 1 tablet by mouth at bedtime for dementia -Start Date-09/12/2024 1900

-Aripiprazole Tablet 5 MG Give 1 tablet by mouth one time a day for depression resistant to treatment Start Date- 09/13/2024

-Bupropion HCl ER (XL) Tablet Extended Release 24 Hour 300 MG Give 1 tablet by mouth one time a

day for depression -Start Date-09/13/2024 -

-Escitalopram Oxalate Tablet 20 MG Give 1 tablet by mouth one time a day for Depression -Start Date-09/13/2024 -

-Levothyroxine Sodium Tablet 75 MCG Give 1 tablet by mouth one time a day for low thyroid hormone Give 1 hour before or after meals -Start Date-09/13/2024 -

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Meloxicam Tablet 15 MG Give 1 tablet by mouth one time a day for anti-inflammatory (left hip pain) Start Date 09/13/2024 Record review of Resident #38's consent for psychotropics revealed Resident #38 and her physician signed the consent to receive Abilify (Aripiprazole) for psychotic behavior. During an interview on 10/30/24 at 2:30PM, the DON said Resident # 38 was admitted to the facility with the medication and she would call Resident #38's physician to clarify the use of Abilify for psychotic behavior. During a phone interview with Resident #38's Physician on 10/30/24 at 4:50PM, she said Resident #38 was already on Abilify at the hospital because Resident # 38 had tried other medication and the result was not favorable and resident #38 responded well to Abilify. She said she would refer Resident #38 to psychiatric for evaluation and proper diagnoses. Facility's policy on the use of psychotropic medication was requested but was not provided prior to exit on 10/30/24.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39977 Based on observations, interviews, and record review the facility failed to provide a safe, functional, sanitary, comfortable environment for 1 resident of 37 (Resident #11), staff and visitors in 1 resident room (room [ROOM NUMBER] W). Resident #11's room [ROOM NUMBER] had 2 unsecured oxygen tanks standing next to each other on the floor. This failure could place residents, staff, and visitors at risk of living and working in an unsafe, dangerous environment. Findings included: Record review of Resident # 11's Admission Record dated 10/30/24 revealed she was a [AGE] year old female who admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses: diffuse traumatic brain injury with loss of consciousness of unspecified duration, post traumatic seizures (seizures that occur after a traumatic brain injury), epilepsy and recurrent seizures (a brain disorder causing recurrent, uncontrolled jerking, movements caused by abnormal activity in the brain), tracheostomy status (surgical procedure that creates an opening in the neck and into the windpipe that helps a person breath), and aphasia (language disorder that affects a person's ability to communicate including inability to speak). Record review of Resident #11's Annual MDS dated [DATE] revealed she was coded as having no ability to talk and her SAMS revealed she was severely cognitively impaired and was dependent on staff assistance for ADL's. Resident #1 was also coded as having tracheostomy care and oxygen therapy in section O of the MDS - Special Treatments, Procedures, and Programs . Observation of Resident #11 on 10/29/24 at 08:34 a.m. revealed 3 oxygen cylinders canisters. The 3 oxygen tanks were standing next to the bedside oxygen concentrator machine. 1 oxygen tank was in a secured metal stand. The other 2 oxygen tanks were standing on the floor with no stand, or cart and they were not secured or anchored to anything to keep them from falling and potentially releasing pressurized oxygen rapidly and turning into a heavy metal projectile. Observation and interview at 8:42 am on 10/29/24 with RN B who when shown the 2 unsecured oxygen tanks standing in Resident #11's room next to a bedside oxygen concentrator (a device that produces a higher concentration of oxygen from the surrounding air). RN B said that Resident #11 had significant family involvement and input into the resident's care, and often requested additional oxygen tanks for use at the bedside. RN B said that the 2 unsecured oxygen tanks should not be free standing on the floor next to the resident's bedside. RN B said other staff sometimes keep the empty tanks at the bedside to have on hand per family request and that someone must have forgotten to remove the oxygen tanks. When asked how the oxygen tanks should be stored, RN A said they should be kept in a stand to secure them and not just left standing on the floor. RN A quickly removed the tanks from Resident #11's bedside and room. RN B said that if the tanks had fallen, they could have blown up and was unsure if they were empty. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER The Meridian		STREET ADDRESS, CITY, STATE, ZIP CODE 2228 Seawall Blvd Galveston, TX 77550	

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with DON at 8:55am on 10/29/24 who was advised of the 2 unsecured, free standing oxygen tanks on the floor in Resident #11's room . The DON said they should not have been there and that they posed a potential hazard if they fell . The DON said the 2 oxygen tanks should have been secured and stored properly per policy and procedure. Record review of facility policy and procedure titled: Fire, Safety and Prevention, dated Revised May 2011, revealed the following: f. Store oxygen cylinders in racks with chains, sturdy portable carts, or approved stands. Never leave oxygen cylinders free-standing. Do not store oxygen cylinders in any resident room or living area; q. Ensure oxygen cylinders in use are on approved carts or stands and are attached to the residents' beds.