STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676286	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Lake Health Center	16044 County Road 165 Tyler, TX 75703

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36491 Based on interviews and record review, the facility failed to immediately notify the resident's physician, and notify, consistent with his or her authority, the resident's representative when there was an accident involving the resident for 1 of 7 residents (Resident #1) reviewed for resident rights. The facility failed to ensure Resident #1's physician and representative were notified after Resident #1 had a fall. This failure could result in the family or guardian not being aware of conditions that may require them to make medical decisions. Findings included: Record review of a facility face sheet dated 5/15/25 indicated Resident #1 was an [AGE] year-old male admitted to the facility on [DATE]. Diagnoses included atherosclerotic heart disease (condition caused by the buildup of plaque in the arteries, leading to reduced blood flow and increasing the risk for heart attacks and strokes), atrial flutter (abnormal heart rhythm), hypertension (high blood pressure), and dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities). Record review of a comprehensive MDS assessment dated [DATE] for Resident #1 indicated that he had a BIMS score of 6, indicating he had severely impaired cognition. Resident was occasionally incontinent of urine and always incontinent of bowel. Record review of a comprehensive care plan dated 5/10/25 for Resident #1 indicated he had an actual fall on 5/10/25 which resulted in a bruise on his forehead related to unsteady gait. Interventions included: determine and address causative factors of the fall, provide activities that promote exercise and strength building where possible. (continued on next page)

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a progress note dated 5/10/25 at 8:00 p.m. and signed by LVN A indicated the following: Resident observed on floor in room beside his bed. Vital signs wnl and neuro checks wnl. Resident assisted from floor to bed per this nurse and one staff member. Resident was dressed in non-skid socks at the time. Prior to fall resident was laying in the bed in his room. Resident observed resting in bed prior to fall. Resident assisted from floor to wheelchair X2 staff. Staff continued to monitor resident. During an interview on 5/15/25 at 10:00 a.m. the DON said Resident #1 had a fall and LVN A did not notify the family, physician, or Hospice. The DON said he had not been made aware of the fall until a family member asked him about the bruise to Resident #1's head. DON said LVN A told him she had forgotten to notify anyone. DON said Resident #1 was admitted for 5 days of respite care and was receiving Hospice services. The DON said LVN A should have notified the physician, family, Hospice and himself of the fall . During an interview on 5/19/25 9:45 a.m. the ADON said when a resident had a fall, staff were to assess, check neuro status, observe skin, and see if they were on blood thinners. The ADON said the NP/physician, DON, ADON, family, and Hospice should all be notified. ADON said LVN A did not notify anyone, and all the above should have been notified . During a phone interview on 5/19/25 at 12:07 p.m. LVN A said she had worked in the facility a little over 3 months. LVN A said she was working on Saturday 5/10/25 when Resident #1 had a fall. LVN A said she was called by the aide and went into the room immediately. Resident #1 was sitting upright on the floor by the bed. LVN A said she assessed him, and his vital signs and neuro checks were good. LVN A said Resident #1 was transferred back to the bed. LVN A said she did not see any open areas, skin tears or bruising. LVN A said the bruise to his forehead did not show up until the next day. LVN A said she had forgotten to call the family. It was a complete oversite on my part. I had gotten busy and just forgot. LVN A said she had received previous training on falls, and reporting, and received more training after this incident. LVN A said she knew the doctor, NP, DON, Administrator, ADON, family and Hospice needed to be notified of any falls or other incidents. LVN A said, it was an oversite on my part, and I'm sorry . During a phone interview on 5/19/25 at 1:21 p.m. CNA B said she had worked in the facility almost 2 years. CNA B said she was working the night Resident #1 had a fall. CNA B said Resident #1 told her he was ready for bed around 6:30-7:00 p.m. CNA B said she put Resident #1 to bed and started to do her charting. CNA B said Resident #1's room was right across from where she was charting. CNA B said she heard a noise in his room and ran in. CNA B said Resident #1 was on the floor trying to get up. CNA B said she told Resident #1 to lay down while she got the nurse. CNA B said the nurse came and assessed Resident #1. CNA B said she could not say what he hit, or if he hit anything when he fell . CNA B said she left that night at 9:45 p.m., and there was no bruising noted on Resident #1. CNA B said when she came back to work the next Monday, Resident #1 had a bruise to his forehead. CNA B said she could not remember what side of his head it was on . Record review of a facility policy titled Falls Prevention and Management Program dated 1/1/2016 and revised 9/23/2019 revealed the following: immediately notify the attending physician and family or guardian of condition changes .