

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER Highland Meadows Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1870 S John King Blvd Rockwall, TX 75032	
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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747 Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that included instructions needed to provide effective and person-centered care for the resident that met professional standards of care within 48 hours of the resident's admission for one (Resident #144) of five residents reviewed for baseline care plans. The facility failed to complete a baseline care plan for Resident #144. This failure could place newly admitted residents at risk of not receiving effective and person-centered care and services. Findings included: Review of Resident #144's Face Sheet, dated 03/03/25, reflected she was a [AGE] year-old female who admitted to the facility on [DATE], with diagnoses including aftercare following joint replacement surgery (a period of pain management, physical therapy, wound care, and gradually returning to normal activities), type 2 diabetes mellitus (a chronic condition where the body either doesn't produce enough insulin, or the cells become resistant to the effects of insulin, leading to high blood glucose (sugar) levels), and heart failure (a chronic condition that occurs when the heart can't pump enough blood to meet the body's needs). Review of Resident #144's electronic medical records on 03/03/25 reflected a baseline care plan had been initiated on 02/25/25 by LVN F, but the baseline care plan was never completed. During an interview with LVN F on 03/03/25 at 12:54PM, he stated baseline care plans were required to be completed within 48 hours of a resident's admission. He stated he was responsible for completing Resident #144's baseline care plan. He said although he initiated the baseline care plan in the facility's electronic charting system, he forgot to complete the document. During an interview with the Director of Nursing on 03/05/25 at 12:00PM, he stated baseline care plans were required to be completed within 48 hours of a resident's admission. He stated there was not an inherent risk to residents if baseline care plans were not completed within this required timeframe, as facility staff communicated closely regarding resident care and ensured all care needs were still met. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Care Plans - Baseline policy, dated 03/2022, reflected, .A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission .		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on observation, interview, and record review, the facility failed to provide care and services to prevent complications for 1 (Resident #31) of 3 residents reviewed with gastrostomy tubes (g-tubes). CNA A did not inform the nurse to turn off Resident #31's gastrostomy tube feeding prior to providing care. CNA A lowered the head of Resident #31's bed to a flat position for incontinent care while the g-tube feeding continued to infuse. This failure could place residents with g- tubes at risk for complications, aspiration, and pneumonia. Findings included: Record review of Resident #31's face sheet dated 03/04/25 revealed a [AGE] year-old female was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #31 had diagnoses included hypertension, , gastrostomy, dementia, mood disturbance, anxiety, seizures, cognitive communication deficit, anemia, hypothyroidism (a condition that happens when your thyroid gland doesn't make or release enough hormone into your bloodstream), vitamin deficiency, and gastro-esophageal reflux disease. Record review of Resident #31's Annually MDS assessment dated [DATE] revealed Resident BIMS was 12 which indicated no impaired cognition. Resident #31 was dependent of staff assistance with ADL with one staff assistant. Further review revealed the resident had a PEG tube. Record review of Resident # 31's care plan initiated on 05/25/21 revealed Resident #31, Focus, requires tube feeding r/t Dysphagia, Resisting eating, Weight Loss. At risk for complications. Goal, Will remain free of side effects or complications related to tube feeding through review date. Intervention, Monitor/document/report to MD PRN: Aspiration- fever, SOB, Tube dislodged, Infection at tube site, Self-extubation, Tube dysfunction or malfunction, Abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distension, tenderness, Constipation or fecal impaction, Diarrhea, Nausea/vomiting, Dehydration. Record review of Resident #31's physician for February 2025 read in part . Enteral Feed Order as needed Nutren 1.5 @ 50 ml/hr x 22 hrs continuous for a total volume of 1100 ml via pump. May allow 2 hour down time for ADL's, Water Flush at 160cc q 6 hours to run concurrent with Nutren . During an observation on 03/03/25 at 11:27 a.m., revealed Resident #31 was lying on the bed and she placed the call light on and asked to be changed. CNA A was observed put on own and gloves and then lowered Resident #31's head of bed. Resident #31 feeding was infusing while CNA A was providing incontinent care. After care CNA A then elevated the resident's head of bed. (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/03/25 at 11:42 am., with CNA A she stated she did not need to inform the charge nurse she was providing care to the resident so the nurse could pause or stop the feeding. CNA A stated while providing care to resident with g-tube the feeding was not paused or stopped during care. CNA A was not aware why the head of bed was not to be lowered when the feeding was infusing. In an interview on 03/03/25 at 12:15 pm., with LVN B revealed she was the charge nurse for Resident #31. LVN B stated Resident #31 did not have pneumonia or aspiration. LVN B stated during incontinent care the aides were supposed to inform the charge nurse so the residents feeding would be turned off. LVN B stated the resident's head of bed was not supposed to be lowered to a flat position while the feeding was infusing. LVN B stated lowering resident head of bed flat while the feeding was infusing would cause aspiration. In an interview on 03/05/25 at 12:24 pm., with the DON he stated the aide was supposed to inform the charge nurse so they could pause the feeding, and the aide was not supposed to provide incontinent care while the feeding was infusing. The DON stated the resident was at risk for aspiration and even pneumonia when head of bed was flat and the feeding infusing. The DON stated CNA A had been in-serviced on providing activities of daily living to residents with a g-tube and had completed skill check off. Requested for a skill check off but was not provided by exit. No policy was provided regarding providing incontinent care on residents who were on continues g-tube feeding. The policy was requested from the DON on 03/05/25. The DON provided a policy dated 03/22, titled Enteral and Parenteral Feeding - Documentation, Orders and Nutrition reflected, . The resident who utilizes enteral or parental nutrition will be free, to the extent possible, from complications related to enteral and parenteral nutrition.		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on interview and record review, the facility failed to ensure the resident's PRN orders for psychotropic drugs were limited to fourteen (14) days for 1 of 6 residents reviewed for unnecessary medications, in that (Residents #70). Resident #70 had a PRN order for Lorazepam, a psychotropic medication, for more than fourteen days without physician documentation re-evaluating the medication to continue it PRN or to become a scheduled medication. This failure could place residents who receive PRN psychotropic medications at risk of receiving unnecessary psychotropic medications. Findings included: Record review of Resident #70's face sheet dated 03/04/25 revealed a [AGE] year-old male was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #70 had diagnoses included, chronic systolic (congestive) heart failure, chronic obstructive pulmonary disease, protein-calorie malnutrition, depression, presence of cardiac pacemaker, orthostatic hypotension, and hyperlipidemia. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #70 had a BIMS score of 14 indicating no severe cognitive impairment. Further indicated the resident had anxiety disorder and he was taking antianxiety medication. Record review of Resident #70's care plan dated 10/07/23 indicated the resident used Ativan for anxiety. The goal was for the resident to show decreased episodes of signs and symptoms of anxiety. Intervention was for the resident to give anti-anxiety medications ordered by physician and monitor/document side effects and effectiveness. Record review of Resident #70's physician's order summary report dated 03/05/25 indicated: Lorazepam oral tablet 1 MG (Lorazepam) give 1 tablet by mouth every 8 hours as needed for anxiety for 6 months, with an order date of 01/09/25 and with a stop date of 07/09/25. Record review of Resident #70's EMAR for the months of February 2015 and March 2025 indicated the resident had not taken Lorazepam medication. Record review of Consultant Pharmacist's Medication Regimen Review dated 1/1/25 and 1/3/25 indicated Resident #70's PRN Lorazepam required 14 days stop date. Can extended with documentation clinical note/rationale, but always required a specific duration or stop date. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/05/25 at 11:10 AM, with ADON D stated Resident #70 received PRN Lorazepam and it was ordered in January 2025. She said she could not show where the medication was re-evaluated every 14 days. She said that type of medication should be re-evaluated every 14 days by the primary care provider because it was a psychotropic medication. She said the risk of not re-evaluating psychotropic medication every 14 days was the resident could be overmedicated. The ADON D stated per the pharmacy notes from January 2025 it indicated the medication needed to be reevaluated every 14 days and ADON E was to follow up. In an interview on 03/05/25 at 01:58 PM with ADON E she stated Resident #70 was on Prn Lorazepam. She stated, she understood if the resident was on hospice they did not require a stop date for psychotropic medication when they were ordered prn. She then stated she realized Resident #70 was no longer on hospice, so she was supposed to follow up with the resident's primary care provider, but she did not. The ADON E stated the medication was supposed to be reviewed every 14 days to check and make sure the resident still required the medication and any changes required to be made, if the resident did not need it then the medication required to be stopped. In an interview on 03/05/25 at 02:23 PM with the DON he stated when any resident was no psych services, he included the psych team. The DON provided the documentation indicating for the resident to be on Lorazepam for 6 months but did not give the rationale for the prolong use of the medication prn. The DON stated review of psychotropic medications every 14 days was to make sure the medication was being used appropriately and to prevent any side effects from the medication. The DON stated he was not aware of the pharmacy recommendation for the medication to be reevaluated. Review of the facility policy revised 7/2022 and titled antipsychotic medication use reflected, Residents will not receive medications that are not clinically indicated to treat a specific condition. 16. PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare profession has evaluated the resident for the appropriateness of that medication and documented the rationale for continued use .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 2 (Residents #31 and #49) of 6 residents reviewed for infection control in that: 1. CNA A failed to complete hand hygiene during incontinent care while assisting Resident #31. 2. CNA C failed to complete hand hygiene and change gloves during incontinent care while assisting Resident #49. These failures could place resident's risk for cross contamination and the spread of infection. Finding include: 1. Record review of Resident #31's face sheet dated 03/04/25 revealed a [AGE] year-old female was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #31 had diagnoses included hypertension, gastrostomy, dementia, mood disturbance, anxiety, seizures, cognitive communication deficit, anemia, hypothyroidism (a condition that happens when your thyroid gland doesn't make or release enough hormone into your bloodstream), vitamin deficiency, and gastro-esophageal reflux disease. Record review of Resident #31's Annually MDS assessment dated [DATE] revealed Resident BIMS was 12 which indicated no impaired cognition. Resident #31 was dependent of staff assistance with ADL with one staff assistant and was always incontinent of bowel and bladder. Record review of Resident # 31's care plan initiated on 05/25/21 revealed Resident #31, Focus, requires assist with all adl's and transfers d/t impaired cognition and mobility. Goal, All needs will be met through the next review date. Interventions, Assist with oral care, hair care, nail care, grooming, dressing, toileting and mobility. During an observation on 03/03/25 at 11:27 a.m., revealed Resident #31 was lying on the bed and she placed the call light on and asked to be changed. CNA A was observed to don gown and gloves and then lowered Resident #31's head of bed. Then CNA A proceeded to provide incontinent care to Resident #31. Resident #31 had a bowel movement and during the care CNA A was observed changing gloves but did not complete any form of hand hygiene. In an interview on 03/03/25 at 11:42 am., with CNA A she stated she was supposed to complete hand hygiene after changing gloves, but she forgot. CNA A stated she was supposed to complete hand hygiene to prevent the spread of infection. CNA A stated she completed infection control in-service monthly. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #49's face sheet dated 03/04/25 revealed a [AGE] year-old female was originally admitted on [DATE] and readmitted on [DATE]. Resident #49 had diagnoses included, vascular dementia, psychotic disturbance, mood disturbance, and anxiety, hypertension, anemia in other chronic diseases, major depressive disorder, chronic kidney disease and weakness. Record review of Resident #49's Quarterly MDS assessment dated [DATE] revealed Resident BIMS was 10 which indicated mild cognition impairment. Resident #49 was dependent on the staff and was always incontinent of bowel and bladder. Record review of the care plan for Resident #49 initiated 09/28/21 reflected, Focus, [Resident #49] is incont of bowel and bladder At risk for skin breakdown and uti's. Goal, Minimize risk for uti's through the next review date. Intervention, Provide incont care after each incont episode. Observation on 03/03/25 at 12:43 pm., revealed CNA C providing incontinent care to Resident #49. CNA C gloved and started providing care to Resident # 49. Resident was soiled with urine, and after CNA C cleaned the resident, she did not change gloves or complete hand hygiene. With the same gloves, CNA C applied the clean brief, touched the resident's linens and bed remote. In an interview on 03/03/25 at 12: 54 pm., with CNA C she sated stated she was not aware of cleaning hands in between care, unless the resident had a bowel movement. CNA C stated she was required to complete hand hygiene before and after care, to prevent the spread of infection or cross contamination. In an interview on 03/05/25 at 12:20 PM with the DON she stated the staff members were expected to complete hand hygiene during care. The DON stated the aides were to wash hands when they enter the room and after taking care of the resident. Training and monitoring was completed by the infection preventionist. After cleaning the residents, the staff were supposed to complete hand hygiene and don clean gloves. The DON stated the staff were in-serviced on infection control monthly. In an interview on 03/05/25 at 01:10 PM with ADON D she stated she was the infection preventionist. The ADON D stated the aides were supposed to complete hand hygiene after changing gloves and after cleaning the residents. ADON D stated the staff were not supposed to touch resident's items with dirty gloves. The ADON stated the staff were to complete hand hygiene to maintain infection control and prevent the spread of infection. The ADON stated the staff were in-serviced on infection control monthly. Review of the facility policy dated 05/2021 and titled, Infection Control - Prevention and Control Program reflected, The intent of this program is to assure that the home develops, implements, and maintains an Infection Prevention and Control Program to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. Review of the facility policy dated 05/2017 and titled, Hand Washing reflected, It is the policy of this home that hand hygiene is the primary means to prevent the spread of infection. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub) shall be readily available and convenient for staff use to encourage the compliance with hand hygiene. 1. 1. The use of gloves does not replace proper hand washing.		