STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455412	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookhaven Nursing and Rehabilitation Center	1855 Cheyenne Carrollton, TX 75010

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427 Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of the resident needs for 2 (Resident #6, and Resident #83) of 5 residents reviewed for resident rights. The facility failed to ensure Resident #6 and Resident #83's call light was placed within reach. These failures could place residents at risk of injuries and unmet needs. Findings included: Review of Resident #6 Quarterly MDS assessment dated [DATE] revealed resident was admitted on [DATE] with readmission on 12/31/2019, diagnoses of cerebral infarction (stroke), dementia (loss of cognition cognitive communication deficit), unsteadiness on feet, difficulty in walking, generalized muscle weakness, and a BIMS score of 7 (severely impaired cognition). Review of Resident #6 Care Plan dated initiated 04/04/2023 and revised 05/03/2024 reflected resident had a history of falls and had a fall with injury to his forehead on 04/04/2024 due to an unsteady gait with the intervention to remind resident to call for help before he got up. Review of Care Plan dated initiated 08/22/2018 and revised on 04/11/2023 reflected Resident #6 had an ADL self-care performance deficit and limited mobility due to a stroke with the intervention of Encourage resident to use bell to call for assistance. Observation on 06/04/2024 at 11:02 AM of Resident #6 revealed resident was laying in a low bed watching television with his call light hanging off the right side of his bed rail. Interview on 06/04/2024 at 11:03 AM with Resident #6 revealed he was alert and slightly confused, he did not know where his call light was and did not know how to find it and stated he could not reach it. Interview on 06/04/2024 at 11:15 AM with CNA O revealed she had worked at the facility for a year and was familiar with Resident #6. CNA O stated that Resident #6 was at risk for falls and stated that his call light was out of his reach which put the resident at risk of having a fall by not being able to call for assistance first. CNA O stated call lights are important to be kept within reach of residents because if a resident fell they would not be able to call for assistance. CNA O placed call light next to resident on the bed. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/05/2024 at 3:51 PM with ADON A revealed Resident #6 was at facility for long term care and had dementia, a history of falls and was on fall precautions which included keeping his bed at a low level, ensure the resident was positioned correctly, and had call light within reach. ADON A stated that she would be concerned if Resident #6's call light was not within reach because even though he was forgetful it was important he had the ability to use the call light. ADON A stated the risk to a resident to not have a call light within reach was that a resident would not be able to call when they need help and could fall. Review of Resident #83 Quarterly MDS assessment dated [DATE] revealed resident was admitted on [DATE] and had the diagnoses of osteoarthritis (disease of the joints), pain in unspecified hip, muscle weakness, unsteadiness on feet, and a BIMS of 6 (severely impaired cognition). Review of Resident #83's Care Plan dated initiated 01/10/2024 and revised on 01/31/2024 reflected resident was at risk for falls due to a history of falls and had an unsteady gait with the intervention of keep call light within reach. Review of Care Plan dated initiated 05/07/2024 reflected Resident #83 was on hospice services and was at risk of decline in mental and physical conditions with an intervention of call light in reach and answer promptly. Observation on 06/04/2024 at 10:50 AM revealed Resident #83 was awake lying in bed, wearing pajamas, with a stuffed animal under his arm and his call light was out of reach, looped and hung on the wall behind the resident's bed. Interview on 06/04/2024 at 10:51 AM with Resident #83 revealed he was not sure where his call light was located. Interview on 06/04/2024 at 10:59 AM with CNA D revealed he had worked at the facility for [AGE] years and stated that the call light should be placed within reach next to Resident #83 and was not sure why it was on the wall. CNA D placed call light next to resident on bed. CNA D stated that Resident #83 was at risk of falls and should always have his call light within reach to be able to call for assistance to get out of bed or to be able to call for help if he did fall. CNA D stated that he was not sure who assisted the resident last because hospice services had also been to visit with resident and that any staff member who previously assisted Resident #83 was responsible to ensure the call light was within reach. CNA D stated the risk to a resident by not having a call light within reach is risk of injury, falling, or not having their needs met. Interview on 06/05/2024 at 3:53 PM with ADON A revealed Resident #83 had dementia, a history of falls, was ambulatory and liked to walk around in his room by himself. ADON A stated that Resident #83 should always have his call light within reach. ADON A stated the risk to a resident who did not have a call light within reach would be they would not be able to get assistance or could fall and not be able to receive assistance. ADON A stated any staff member who assisted residents was responsible for ensuring call lights were placed within their reach and it was important to ensure residents had their needs met and prevent possible injury. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/06/2024 at 10:30 AM with DON revealed he had worked at the facility for about 2 months and was familiar with Resident #6 and Resident #83. DON stated that Resident #6 ambulates himself with a wheelchair and had difficultly expressing himself verbally. DON stated Resident #6 was at a high risk of falls because his gait was unsteady and that his call light should always be within his reach so he could ask for assistance. DON stated that Resident #83 was alert but confused and currently was on hospice services and should always have call light within reach so resident could call for assistance if needed. DON stated any staff member including CNAs or RNs are supposed to ensure the call lights were within reach when they round and provide care to residents. DON stated that having a call light within reach of residents was important for safety reasons, so residents are able to call for assistance and have their needs met. Interview on 06/06/2024 at 12:56 PM with Administrator revealed she was familiar with Resident #6 and Resident #83 and stated they were both at high risk of falls and should always have their call light within reach. Administrator stated it was important that all residents had their call lights within reach because it was their policy and a safety precaution and ensured residents received assistance that they needed. Facility policy on resident call lights was requested on 06/05/2024 and facility provided safety policy titled Safety and Supervision of Residents. Review of safety policy reflected: Systems Approach to Safety . facility-oriented and resident-oriented approaches to safety are used to gather to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 2 (Resident #53, Resident #74) of 8 residents reviewed for ADLs. The facility failed to ensure: 1- Resident #53 had her fingernails cleaned and trimmed. 2- Resident #74 had his fingernails cleaned and trimmed. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life. Findings include: 1-Record review of Resident #53's Quarterly MDS assessment dated [DATE] reflected Resident #53 was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), Hemiplegia (paralysis that affects only one side of the body) affecting right side, and dementia. Resident #53's cognition was severely impaired. Resident #53 was always incontinent of bowel and bladder and required assistance with personal hygiene. Review of Resident #53's Comprehensive Care Plan, revised 06/08/23, reflected the following: Focus: [Resident #53] required assistance from staff with ADL. Goal: [Resident #53] will remain clean, comfortable, well groomed, and will maintain optimal mobility on daily basis. Interventions: Staff will encourage resident to participate with ADLs as able. Staff to assist with / provide ADLs as needed. An observation and interview on 06/04/24 at 11:33 AM revealed Resident #53's right hand contracted with fingernails were approximately 0.5 inches long. Fingernails on the left hand were long, dirty, and chipped. In an interview with Resident #53 stated she would like the fingernails to be trimmed and cleaned. 2.A record review of Resident #74's Quarterly MDS assessment dated [DATE] reflected Resident #74 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses included dementia, age related physical debility, and lack of coordination. Resident #74 had a BIMS of 11 which indicated Resident #74's cognition was moderately impaired. She required extensive assistance of two-person physical assistance with personal hygiene. A record review of Resident #74's Comprehensive Care Plan, revised 03/27/23, reflected the following: Focus: [Resident #74] required assistance from staff with ADL. Goal: [Resident #74] will remain clean, comfortable, well groomed, and will maintain optimal mobility on daily basis. Interventions: Staff will encourage resident to participate with ADLs as able. Staff to assist with / provide ADLs as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 06/04/24 at 11:33 AM revealed Resident #74 was laying in her bed. The nails on both hands were approximately 0.3 centimeter in length extending from the tip of her fingers. The nails were discolored tan and the underside had dark brown colored residue. Resident #74 was unable to answer questions. In an interview with CNA M on 06/04/24 at 11:40 AM, she stated both CNAs and LVNs were responsible for nail care. She stated if a resident has diabetes, only nurses were allowed to provide nailcare. She stated the risk for not performing nailcare was increased risk of infection. She stated both Resident #53 and #74 were not diabetics and she offered to clean and trim their fingernails after the interview. In an interview with the DON on 06/06/24 at 8:40 AM revealed his expectation was that nail care should be provided every Sunday or as needed, especially during shower time. He stated that CNAs were responsible for doing nail care unless the resident had a diagnosis of diabetes. He also stated that as the DON, either himself or his designee were responsible to do routine rounds for monitoring. The DON stated residents having long and dirty fingernails could be an infection control issue and skin breakdown. Record Review of the facility policy titled Activities of Daily Living, Supporting not dated 1, 2023 reflected, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review, the facility failed to ensure that based on the comprehensive assessment of a resident, the residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one of 21 residents (Resident #44) reviewed for quality of care. The facility staff failed to ensure Resident #44's splint was placed on his right arm and hand on 06/04/24 and 06/05/24 per physician orders. These failures could place residents at risk of not receiving the care and treatment needed to meet their needs and could result in decreased Range of Motion and worsening of contractures. Findings included: Record review of Resident #44's face sheet dated 06/06/24 reflected a [AGE] year-old male admitted to the facility on [DATE] with a diagnosis of aphasia (loss of ability to understand or express speech caused by brain damage), hemiplegia right side (paralysis), and cerebral vascular accident (stroke). Record review of Resident #44's quarterly MDS assessment dated [DATE] reflected a staff assessment for mental status determined the resident was moderately cognitively impaired, he was dependent for his ADL needs and had one side functional limitations in range of motion on both upper and lower limbs. Record review of Resident #44's care plan initiated 11/28/22 reflected, [Resident #44] have right hand that requires splinting related to Cerebral Vascular Accident and contractures .Goal .Maintain current function and prevention of further contractures .Interventions .Right hand splint to be worn daily at 08:00 a.m. and remove splint at 2 p.m. Nursing to apply Right hand splint with wearing schedule daily as tolerated. Record review of Resident #44's Physician order Summary Report dated 06/05/24 reflected, Right hand splint to be worn daily at 8 am and removed splint at 2 pm two times a day with a start date of 01/03/23. Record review of Resident #44's MAR and TAR for June 2024 at 09:45 a.m. reflected RN C had signed the TAR on 06/04/24 which indicated the splint had been placed on at 8 a.m. and off at 2 p.m. and on 06/05/24 it was signed off which indicated the splint had been placed on at 8 a.m. In an observation on 06/04/24 at 10:20 a.m., Resident #44 was observed lying in bed. Resident indicated he was doing okay. Right hand noted to be clenched in a tight fist. No splint in use. Resident was unable to open his right hand. In an observation on 06/04/24 at 12:15 p.m. resident #44 was observed up in a Geri-chair (reclining wheelchair) in the dining room. Family members present. No splint on right hand. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 06/05/24 at 09:30 a.m. Resident #44 was observed in bed. No splint or hand rolls observed on right hand. In an observation on 06/05/24 at 11:10 a.m. Resident #44 remained in bed. No splint in place on resident's right hand. In an observation and interview on 06/05/24 at 11:30 a.m. CNA H entered Resident #44's room to get him up for the day. CNA H stated the CNAs and sometimes therapy are responsible for putting the resident's splint on. She stated she had not put the splint on this morning (06/05/24) because she had just now got his clothes changed. In an interview on 06/05/24 at 11:35 a.m. with RN C, she stated the nurses were responsible for monitoring to ensure the splints were in place for any resident who had orders for splint placement. She stated she thought Resident #44's splint had been placed on the resident. She stated she was not sure why his splint was not on 06/04/24, and again on 06/05/24. She stated she does not check off on the TAR if the splint was not in place and stated the CNAs should be informing her if they had taken it off since he had specific order for it to be in place from 8 am to 2 p.m. In an interview on 06/05/24 at 11:40 a.m. with CNA I, she stated she was assigned to Resident # 44 on 06/04/24. She stated she does not normally work that hall and was not familiar with the resident. She stated she did not put a splint on the resident stating she was not aware he had a splint. She stated an unknown Nurse had told her to put a washcloth in his hand but did not say anything about a splint. She stated she thought the Nurses were responsible for putting on splints. In an interview on 06/05/24 at 11:45 a.m. with ADON A, she stated the nurses were responsible for ensuring splints were in place if they had an order for splint placement. She stated the nurse, or the CNA could put the splints on the resident. She stated the nurse needed to assess the skin at the time of the removal of the splint to ensure no skin issues. She stated failure to ensure placement of splints could result in a decline of mobility and worsening of contractures. On 06/05/24 at 12:50 p.m. Resident # 44 was observed sitting up in Geri-chair in the dining room with family present. Right hand splint was now in place. Interview with resident's Family member, stated the resident did not have his splint on yesterday (06/04/24) when they came at noon. She stated he usually had it on. In an interview on 06/05/24 at 02:10 p.m. with the DON, he stated the nurses were responsible for ensuring the splints were in place and should not sign off on the TAR indicating it was in place when it was not. He stated the CNAs had all been trained on splint placement and could put the splints on and take them off, but the nurse needed to ensure the resident was wearing the splint the prescribed amount of time, and if not the reason why. He stated the nurse should also check the skin when the splint is removed. He stated failure to follow the prescribed amount of time or failure to place the splints on a resident could lead to worsening of the contractures and loss of mobility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's undated policy titled, Resident Mobility and Range of Motion, reflected, Resident's will not experience an avoidable reduction in range of motion .Resident with limited range of motion will receive treatment and services to increase and/ or prevent a further decrease in ROM .Residents with limited mobility will receive interventions per the plan of care, which include appropriate services, equipment such as splints and other devices and assistance to maintain or improve mobility unless reduction in mobility is unavoidable .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on observation, interview and record review, the facility failed to ensure that each resident received adequate supervision for one Resident (Resident #51) of three residents reviewed for supervision. The facility failed to ensure Resident #51 received two-person assist when providing incontinent care. This failure could place residents at risk for accidents and injury. The findings were: Record review of Resident #51's Face sheet dated 06/06/24 reflected Resident #51 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included paraplegia (paralysis that affects legs, but not arms) and chronic respiratory failure. Record review of Resident #51's Comprehensive MDS assessment, dated 04/05/24, reflected Resident #51's cognition was severely impaired. The MDS assessment indicated Resident #51 was dependent of care for all ADLs. He requires 2 persons assist with roll left and right. He was always incontinent of urine and bowel. Record review of Resident #51's Care Plan initiated 04/21/20 revealed he requires total assistance from staff with ADLs. Requires total assist from staff on bed mobility, transfers, locomotion on unit, locomotion off unit, dressing, eating, toilet use, personal hygiene, bathing. Observation on 06/04/24 at 10:13 AM revealed CNA L entered Resident #51's room to provide incontinence care. CNA L had gloves in her hands, she unfastened Resident #51's brief and cleaned down each groin, across the pubic area and retracted the foreskin and cleaned the tip of the penis wiped down the shaft. She rolled resident on his side without assistance. She removed her gloves and put on clean gloves without performing hand hygiene. She wiped the resident's buttock area with peri-wipes, front to back. She then removed the soiled brief and with soiled gloves, placed the clean brief under the resident. LVN N entered the room she helped CNA L to roll Resident #51 on his back onto the clean brief. LVN N left the room to bring clean linen, CNA L fastened the resident's brief and she pulled resident up in bed without assistance. LVN N entered the room with clean lines, CNA L covered Resident #51 with the blanket. Both staff removed their gloves and washed their hands. In an interview on 06/04/24 at 10:45 AM, CNA L stated she changed Resident #51 by herself, and LVN N had come to help at a part of the care. CNA L stated lots of times she was on the hall by herself and would not have help. CNA L stated she sometimes will call for someone to help her if she sees them in the hall. CNA L stated if a resident was a two person assist and only one person assisted, either the CNA or the resident could get hurt. CNA L stated Resident #51 was 2 person assist to roll in bed. She stated she should call the nurse to help her to pull resident up in bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/04/24 at 11:04 AM, LVN N stated when a CNA would come to say they need help, LVN N stated if she was not in the middle of something, he would go with the CNA to assist with whatever they needed. LVN N stated for mornings, there were five CNAs working on the hall. LVN N stated there was enough staff working on the floor. In an interview on 06/06/24 at 09:10 AM, the DON stated he told CNAs to ask for help if they would have a heavy resident. The DON stated nurses would look first at the MDS for how much assist a resident needed for ADLs. The DON stated they would then check the resident's care plan, but the first check would be MDS. DON stated the negative outcome for a CNA or resident using a one person assist on a resident instead of two-person assist could be improper care, falls or injury. Review of facility's policy titled Safety and Supervision of Residents, not dated, revealed: . Resident safety and supervision and assistance to prevent accidents are facility-Wide priorities . Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for three of five residents (Resident #52, Resident #70, and Resident #85) reviewed for catheter care. 1. The facility failed to ensure CNA D and CNA E maintained the foley catheter drainage bag below Resident #52's bladder during a mechanical lift transfer. 2. The facility failed to ensure RN P maintained Resident #70's foley catheter drainage bag below the bladder level during wound care on 06/03/24. 3. The facility failed to ensure Resident #85's catheter bag did not had contact with the floor. This failure placed residents at risk for not receiving care appropriate to address their incontinence. Findings included: 1. Record review of Resident #52's face sheet dated 06//06/24, reflected a [AGE] year-old male admitted to the facility on [DATE]. Diagnoses included obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional), diabetes and obesity. Record review of Resident #52's quarterly MDS assessment dated [DATE] reflected he had a BIMS of 15 which indicted he was cognitively intact, required substantial/maximum assist with toileting and transfers and was frequently incontinent of urine and always incontinent of bowel. Record review of Resident #52's care plan initiated on 04/23/24 reflected, Risk for infection related to foley catheter .Goal .Resident will remain free from signs and symptoms of infection due to catheter .Interventions . Staff will provide catheter care every shift as ordered/indicated . Review of Resident #52's Order Summary report dated 06/06/24, reflected, .Foley catheter care q shift and PRN, Clean with soap and water Keep bag off floor and below bladder level every shift for infection control with a start date of 01/29/24. Observation on 06/06/24 at 09:50 a.m. revealed CNA D and CNA E entered Resident #52's room to get the resident up for the day. CNA D emptied the catheter drainage bag and placed it on the bed while preparing to place the mechanical lift sling under the resident. Both staff positioned the resident on the sling. CNA E picked up the catheter drainage bag and handed it CNA D, who then handed it to Resident #52, and he placed it top of his abdomen. The staff raised the resident from the bed with the catheter drainage bag remaining on the resident's abdomen, above the resident's bladder. Urine was observed flowing back toward the resident's bladder. The staff then positioned him over his wheelchair and lowered him into his chair and then placed the catheter bag onto the side of his wheelchair. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with CNA D on 06/06/24 at 09:55 a.m., he stated she was trained to always keep the catheter drainage bag below the bladder. He stated having it above the bladder could possibility cause the urine to run backwards, which could cause an infection. He stated placing the bag on the bed could cause a risk of cross contamination. In an interview with CNA E on 06/06/24 at 09:58 a.m. she stated they should not have placed the catheter bag in Resident #52's lap. She stated when the resident held out his hand for the bag, they just handed it to him without thinking. She stated she knew the catheter bag and tubing were supposed to be kept below the bladder. She stated failing to do this could cause the urine to back up and might cause an infection. In an interview with the DON on 06/06/24 at 11:30 a.m., he stated any resident with a foley catheter should always have the bag and tubing below the bladder. He stated not keeping the foley catheter bag below the resident's bladder, placed them at risk of a urinary tract infection and cross contamination. He stated to ensure staff were knowledgeable in the care of indwelling catheter the facility does skills competency checks and he stated the ADONs, and Charge Nurses made daily rounds and watched care. He stated when staff needed to be re-trained, he provided the in-service training. Record review of CNA D's competency check off for catheter care revealed he was proficient in care as of 02/16/24. Record review of CNA E's competency check off for catheter care revealed she was proficient in care as of 02/16/24. 2. A record review of Resident #70's Comprehensive MDS assessment dated [DATE] reflected Resident #70 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included morbid (severe) obesity due to excess calories, chronic heart failure, and metabolic encephalopathy (a brain disorder caused by a chemical imbalance in the blood due to an illness or organ dysfunction). Resident #70 had a BIMS of 15 which indicated Resident #70's cognition was intact. She had a stage 4 pressure ulcer to the sacrum. She required extensive assistance of two-person physical assistance with personal hygiene and toileting. Record review of Resident #70's care plan initiated on 05/02/24 reflected, [Resident #70] has indwelling foley catheter (a catheter that's inserted into the bladder through the urethra and left in place to drain urine) related to stage 4 wound .Goal . No injury related to catheter and [Resident #70] will remain free from signs and symptoms of infection due to catheter . Review of Resident #70's Order Summary report dated 06/06/24, reflected, Foley catheter care every shift and PRN (as needed), clean with soap and water keep bag off floor and below bladder level with a start date of 04/17/24. Observation on 06/06/24 at 10:33 AM revealed RN P entered Resident #70's room to do wound treatment. RN P unhooked the catheter bag from the bed rail and put it flat on the foot of bed, above the resident's bladder. RN P provided wound care to sacral wound. During the procedure urine was observed flowing back toward the resident's bladder. The staff finished the treatment and then hooked the catheter bag onto the bed rail. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with RN P on 06/06/24 at 10:53 AM she stated she should not have placed the catheter bag on the bed. She stated she knew the catheter bag and tubing were supposed to be kept below the bladder. She stated failing to do this could cause the urine to back up and might cause an infection. 3. Record review of Resident #85's Annual MDS assessment, dated 03/22/2024, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #85 had diagnoses which included: hypertension (high blood pressure), Gastroesophageal Reflux Disease (condition in which stomach acid repeatedly flows back up into the food tube), Anxiety, and Depression (common mental disorder). He was always incontinent of urine and bowel and had a Foley catheter. Resident had BIMS of 9 suggesting Resident #85 had moderate cognitive impairment. Record review of Resident #85's active Physician order dated 7/20/2023 reflected Foley catheter Care every shift and as needed, Clean with soap and water; Keep bag off floor and below bladder level every shift for Infection Control. Record review of Resident #85's comprehensive care plan, dated 04/05/2024, reflected Focus [Resident #85] has indwelling foley catheter. Goals: No injury related to catheter over next 90 days. Interventions: Ensure that catheter is secured to leg and drainage bag is covered. In an Observation and Interview on 06/04/24 at 11:28 AM revealed Resident #85 was in his wheelchair and the catheter bag was in contact with the floor. Resident #85 stated that he had often seen the catheter bag touching the floor many times. Resident #85 then proceeded to pick up the catheter bag tubing and placed it back on the side of his wheelchair. Interview with CNA Q on 06/04/24 at 11:34 AM revealed the catheter bag should not be touching the floor. She stated the CNA or nurses were responsible for emptying the bag. She did not see the catheter bag tubing on the floor until the time of this interview. She stated if the catheter bag was on the floor it could lead to increased risk of infections. In an interview with RN J on 06/5/24 at 2:52 PM revealed the catheter bag tubing should never touch the floor because of increased risk of infection. She stated that she was assigned to the resident and did not see the catheter bag on the floor until the time of this interview. She stated that Resident #85 was not compliant with keeping the catheter tubing off the floor. She stated that Resident #85 had several urine infections in the past and the risk of not keeping the catheter tubing off the floor can lead to increased risk of infection. In an interview with the DON on 6/5/24 at 2:56 PM revealed his expectation was the catheter bag should always be off the ground and below the resident's bladder, per nursing standards. He stated the risk for having a catheter bag in contact with the floor was increased risk for infections. Review of the facility's undated policy titled, Catheter Care, Urinary, reflected, The purpose of this procedure is to prevent catheter-associated urinary tract infections .The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder .Infection control .Use standard precautions when handling or manipulating the drainage system .Be sure the catheter tubing and drainage bag are kept off the floor . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42971 48560

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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 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** 48560 Based on observations, interviews, and record review the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 of 2 residents (Resident #26) reviewed for feeding tubes. The facility failed to ensure Resident #26's hydration bag for the tube feeding pump was labeled and dated. This failure could result in complications of enteral feedings such as receiving incorrect hydration or elevated risk of infection with using the same hydration bag over multiple days. The findings were: Review of Resident #26's Quarterly MDS assessment dated [DATE] revealed that Resident #26 was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included Cancer (abnormal proliferation of cells), Hypertension (high blood pressure) and Heart Failure (insufficient pumping of the heart) and unspecified Neurological conditions (disease that affects the nervous system). Resident #26 had a feeding tube. Resident #26 had BIMS score of 8 suggesting moderate cognitive impairment. Review of Resident #26's comprehensive care plan revised 11/2/2023 revealed, Focus: [Resident #26] requires tube feeding related to Dysphagia , Swallowing problem, Weight Loss. Goal: [Resident#26] will maintain adequate nutritional and hydration status as evidenced by weight stable, no signs and symptoms of malnutrition or dehydration through review date. Intervention: [Resident #26] is dependent with tube feeding and water flushes. See Physician orders for current feeding orders. Review of Resident #26's Physician order dated 1/15/2024 revealed Free Water Flush 200 mL via feeding tube four times a day. In an observation on 06/04/24 at 11:20AM, Resident #26 was lying in bed. Resident #26 had an enteral feeding pump at her bedside which was running into her G-tube (a tube inserted through the belly that brings nutrition directly to the stomach). The feeding pump had 2 bags hanging; one was marked and dated as tube feeding formula and time hung. The second bag had colorless liquid , without a label with content or date it was hung or resident's name. In an interview with Resident #26, she stated that the nurses hung the bags in the morning, but she did not know anything about the contents of the bag. She stated that she received all her nutrition via G-tube and did not have any oral means of nutrition. (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 observation and Interview on 06/04/24 at 11:37 AM with RN J stated that Resident #26 was dependent on tube feedings. She stated that Resident #26's tube feeding had 2 bags - one bag was for the tube feeding formula and the other bag was for hydration. RN J stated that she identified the bag with colorless liquid was hydration bag and stated that the bag did not have a label with contents, hung time or Resident identifier. She stated that both the bags should be labeled with content, date with the time it was hung and should have Resident identifier. She further stated that all Enteral feeding bags should be dated and labeled each time before administering the feeds. She stated that the risk of not dating the tube feed bag was an increased risk of infection related to an unknown hung date and risk of not labeling the bag was probably hanging an incorrect tube feed formula. In an interview on 06/05/24 at 02:54 PM with the DON revealed that it was a standard nursing protocol to date and label tube feed formula and hydration bag with its contents, date feedings started, and resident identifier. His expectation was that all nursing staff follow standard protocols. He stated that risk of not dating and labeling tube feeding hydration bag was a possibility of the same bag being used for the resident for multiple days and spread of microbial infection. Record review of the facility's Enteral Nutrition Therapy policy undated, reflected, 2. The recommendation to initiate the use of enteral nutrition is based on the results of the comprehensive nutritional assessment and is consistent with current standards of practice the resident's advance directives, treatment goals and facility policies. Recommendation from American Society for Parenteral and Enteral Nutrition Safe Practices for Enteral Nutrition Therapy dated January 2017 Practice Recommendations Standardize the labels for all Enteral formula containers, bags, or syringes to include who prepared the formula, date/time it was prepared, and date and time it was started.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42971 Based on observation, interview, and record 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 1 medication cart (Nurses cart hall 300) of 3 medication carts reviewed for pharmacy services. The facility failed remove damaged medications from the Nurses Cart hall 300 timely for disposition. This failure could place residents at risk of not having the medication available due to possible drug diversion and at risk of not receiving the intended therapeutic benefit of the medication. Findings Included: Record review and observation on 06/04/24 at 12:17 PM of Nurses Cart Hall 300, with LVN N revealed: - the blister pack for Resident #39's tramadol 50 mg tablet (controlled medication used for pain) had 2 blister seals broken and the pills still inside the broken blisters and taped over. - the blister pack for Resident #50's tramadol 50 mg tablet (controlled medication used for pain) had 6 blister seals broken and the pills still inside the broken blisters and taped over. - the blister pack for Resident #55's tramadol 50 mg tablet (controlled medication used for pain) had 3 blister seals broken and the pills still inside the broken blisters and taped over. Interview on 06/04/24 at 12:28 PM, LVN N stated she saw the broken blisters with tape during the change of shift count at the start of her shift on 06/04/24. LVN N stated she got busy and forgot to report to the DON. She stated she was not aware of who might have damaged the blister packs. She stated the risk would be a potential for drug diversion. She stated the nurses and med aides were responsible to check the medication blister packs for broken seals during the count of narcotics during the change of the shift. She stated she would report it to the DON and would discard the pills with another nurse. Interview on 06/06/24 at 8:40 AM, the DON stated he expected if a blister pack medication seal was broken the pill should be discarded. The DON stated it would not be acceptable to keep a pill in a blister pack that was opened. The DON stated the risk would be potential for drug diversion and infection control issue. He stated nurses were responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated the ADON, and the DON were supposed to check the carts weekly. Record review of the facility's policy Storage of Medication not dated, reflected the following: . 5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48560 Based on observations, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen in that: 1. The facility failed to ensure food items in the facility refrigerator and freezer had a visible use-by date and covered. 2. The facility failed to discard food stored in the refrigerator that should no longer be consumed. 3. The facility failed to ensure staff were only using clean utensils when accessing bulk foods. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination. Findings included: Observation in facility's walk-in freezer on 06/04/24 at 09:36 AM revealed beef patties were not covered appropriately. Observation in Facility's refrigerator on 06/04/24 at 09:42 AM revealed a bunch of cilantro was rotten and a box of diced potato did not have a visible use-by date on it. Observation in facility's kitchen's prep area on 06/04/24 at 09:51 AM revealed scoop left in the bulk sugar container. In an interview on 06/05/24 at 12:40 PM with the Dietary Manager revealed that she was not aware that the beef patties were not appropriately covered and could cause freezer burn. She also stated that she saw the cilantro was spoiled in the refrigerator on the morning of this interview and will throw away the produce. She stated that the box of diced potatoes was dated with 'use by date' and date was marked on the tape. When the box was open, the tape was torn and hence the use-by date was not legible on the box. She stated that cooks, dietary aides, and herself were responsible for dating and covering all food items in the kitchen. She stated Cooks or dietary aides opened the bulk sugar container each day for food prep and may have inadvertently left the spoon in the bin. She stated it was her expectation that scoop should not be left in bulk container. The Dietary manager stated the risk of leaving scoop inside container can cause cross contamination. She stated not covering food items, not labeling food items appropriately or utilizing spoiled produce could be a risk to residents for food borne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/05/24 at 12:51 PM with [NAME] K revealed she was working in the facility since April 2024. She stated cooks, dietary aides, and the dietary manager were responsible for dating and covering all food items. She stated all foods should be dated with use-by date. She stated if food items were not covered or dated appropriately, it could get the residents sick or cause food infection. She stated she knew that the scoops should be placed outside of the bin, and stated was not sure who placed the scoop inside the bin. She stated that failure to place scoop outside of the containers can lead to cross contamination and possible food poisoning for the residents. Record Review of facility's policy titled Food Receiving and Storage undated reflected, Foods shall be received and stored in a manner that complies with safe food handling practices 8. All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date) 11. The freezer must keep frozen foods frozen solid. Wrappers of frozen foods must stay intact until thawing. Review of the Food and Drug Administration Food Code, dated 2022, reflected, .3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food, or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food 3-305.11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety Review of FDA food code dated 2022 reflected 3-304.12 In-Use Utensils, Between-Use Storage. During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored: (A) Except as specified under (B) of this section, in the food with their handles above the top of the food and the container; (B) In food that is not time/temperature control for safety food with their handles above the top of the food within containers or equipment that can be closed, such as bins of sugar, flour, or cinnamon .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 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 and to help prevent the development and transmission of communicable diseases and infections for three of sixteen residents (Resident #78, Resident #13, and Resident #51) observed for infection control. 1. The facility failed to ensure that CNA D performed hand hygiene while providing incontinence care to Resident #78 on 06/04/24. 2. The facility failed to ensure that CNA F changed his gloves and performed hand hygiene while providing incontinence care to Resident #13 on 06/04/24. 3. The facility failed to ensure that CNA L changed her gloves and performed hand hygiene while providing incontinence care to Resident #51 on 06/04/24. These failures could place the residents at risk of cross-contamination and development of infection. Findings included: 1. Record review of Resident #78's Face sheet dated 06/06/24 reflected a [AGE] year-old male with an admitted [DATE]. Diagnoses included cerebral infarction (disrupted blood flow to the brain), hemiplegia affecting right side (paralysis) and chronic kidney disease. Record review of Resident #78's quarterly MDS assessment dated [DATE] reflected resident had a BIMS of 2 which indicated he was severely cognitively impaired. He was dependent for ADL care and was frequently incontinent of bladder and bowel. An observation on 06/04/24 at 11:30 a.m. revealed CNA D and CNA E entered Resident #78's room to provide incontinence care. Both staff washed their hands and put on gloves. CNA D unfastened the resident's brief and cleaned down each groin, across the pubic area and retracted the foreskin and cleaned the tip of the penis, wiped down the shaft and changed the wipes with each pass. Both staff assisted the resident onto his side revealing he had a moderate bowel movement. CNA D cleaned the resident from front to back, removed his gloves and put on clean gloves without performing hand hygiene. CNA D placed a clean brief under the resident and both staff repositioned the resident back onto his back and fastened the brief. Both staff then removed their gloves and washed their hands. In an interview with CNA D on 06/04/24 at11:20 a.m. he stated he was supposed to do hand hygiene before, after cleaning the resident, and when he changed his gloves and after completion. He stated he forgot to do hand hygiene when he changed his gloves after cleaning the resident. He stated the risk for failing to do hand hygiene was infection and cross contamination. Record review of CNA D's competency check off for hand hygiene revealed he was proficient in care as of 02/16/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #13's Face sheet dated 06/06/24 reflected a [AGE] year-old female with an admitted [DATE]. Diagnoses included multiple sclerosis (chronic disease of the central nervous system), and overactive bladder. Record review of Resident #13's quarterly MDS assessment, dated 05/07/24, reflected she had a BIMS of 9 which indicated she was moderately cognitively impaired. She was dependent of care for all ADL. She was frequently incontinent of urine and always incontinent of bowel. In an observation on 06/04/24 at 03:20 p.m. CNA F and CNA G were observed entering Resident #13's room to transfer resident with a mechanical lift from her Geri-chair to the bed. Both staff washed their hands and put on gloves. The resident was transferred without incident. CNA F removed his gloves and left the room without performing hand hygiene to retrieve supplies for incontinences care. CNA F returned to the room and put on gloves without performing hand hygiene. CNA F opened the resident's brief and wiped down each groin, across the pubic area and down the middle using a different wipe each time. Both staff rolled the resident onto her side and CNA F removed the soiled brief and placed a clean brief under the resident before cleaning her peri anal area and buttocks. CNA F proceeded to wipe the resident's anal area revealing small bowel movement which fell on to the clean brief. CNA F picked up the bowel movement with a wipe, leaving a smear on the upper portion of the brief, and threw it into the trash can. CNA F continued with peri care and rolled the resident back onto the soiled brief and fastened the brief. Wearing the same gloves, CNA F adjusted the bed, and both staff removed the resident's gown and put a clean gown, covered her up and repositioned her in the bed. Both staff removed their gloves and washed their hands. In an interview on 06/06/24 at 03:40 p.m. with CNA F he stated he was supposed to wash his hands before and after care. He stated he was not aware he had to change his gloves after he finished cleaning the resident and before touching the clean brief or the resident's clean gown. He then stated he could see the risk of infections. He stated he should have washed his hands when he came back into the room with the supplies. In an interview on 06/04/24 at 03:50 p.m. with ADON A she stated staff were supposed to wash hands and change gloves before, after completion of cleaning a resident, and after completion of care. She stated she did the skills checks on her CNAs and any additional training they might need. She stated they were all taught to change their gloves when going from dirty to clean. She stated the risk of failing to perform hand hygiene is increased infections and cross contamination. 3. Record review of Resident #51's Face sheet dated 06/06/24 reflected Resident #51 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included paraplegia (paralysis that affects legs, but not arms) and chronic respiratory failure Record review of Resident #51's Comprehensive MDS assessment, dated 04/05/24, reflected Resident #51's cognition was severely impaired. The MDS assessment indicated Resident #51 was dependent of care for all ADLs. He requires 2 persons assist with rolling left and right. He was always incontinent of urine and bowel. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455412	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookhaven Nursing and Rehabilitation Center	1855 Cheyenne Carrollton, TX 75010

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/04/24 at 10:13 AM revealed CNA L entered Resident #51's room to provide incontinence care. CNA L had gloves in her hands. She unfastened Resident #51's brief and cleaned down each groin, across the pubic area and retracted the foreskin and cleaned the tip of the penis and wiped down the shaft She removed her gloves and put on clean gloves without performing hand hygiene. She wiped the resident's buttock area with peri-wipes, front to back. She then removed the soiled brief and with soiled gloves, placed the clean brief under the resident. LVN N entered the room, and she helped CNA L to roll Resident #51 on his back onto the clean brief. LVN N left the room to bring clean linen. CNA L fastened the resident's brief. LVN N entered the room with clean linens, and CNA L covered Resident #51 with the blanket. Both staff removed their gloves and washed their hands. In an interview on 06/04/24 at 10:45 AM, CNA L stated she was supposed to do hand hygiene before, after, and in the middle of the procedure of incontinent care. She stated she should change her gloves and perform hand hygiene when she went from dirty to clean. She stated she was nervous and forgot to change gloves and perform hand hygiene. CNA L stated failing to provide proper care exposed the resident to infections. Record review of CNA L's competency check off for hand hygiene revealed she was proficient in care as of 08/28/23. In an interview on 06/06/24 at 11:11 a.m. with the DON he stated hand hygiene was to be done before incontinence care and staff were required to change their gloves and perform hand hygiene after cleaning the resident and before placing a clean brief or clothing on them. He stated they were required to perform hand hygiene after completion of care. He stated the ADONs did the skill checks on the staff, and he expected the ADON's and Charge nurses to make rounds and observe care provided by the staff. He stated if the ADON's or Charge nurses determine additional training was needed then he provided the training through in-services. He stated the failure to follow the procedure was risk of infection and cross contamination. Record review of CNA F's skill checks he was skills checked on 06/04/24 and were competent in hand hygiene and perineal care. In a follow up interview with ADON A on 06/06/24 at 02:00 p.m. she stated she had been unable to locate CNA's F and G previous skills checks. She stated she knew the previous DON had performed those skills checks because they had a clinic where all the staff were skills checked with a mannequin, but stated she could not locate the documents. She stated she re-educated both staff and checked their competency on 06/04/24. Record review of the facility's undated policy titled, Handwashing/Hand Hygiene, reflected, The Facility considers hand hygiene the primary means to prevent the spread of infections All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection .Wash hands with soap and water .when hands are visibly soiled .Use an alcohol-based hand rub .Before and after direct contact with residents .Before moving from a contaminated body site to a clean body site during resident care .After removing gloves .Hand hygiene is the final step after removing and disposing of personal protective equipment .The use of gloves does not replace hand washing/hand hygiene . 42971