STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455731	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health & Rehab Center of Garland	1201 Colonel Drive Garland, TX 75043

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on observation, interview and record review, the facility who acts as the fiduciary of the residents' fund, failed to hold, safeguard, manage and account for the personal funds of the resident deposited with the facility, to include the right to know, in advance, what charges a facility may impose against a resident's personal funds for one (Resident #3) of three residents reviewed for trust fund management. The facility failed to ensure Resident #3's trust fund account was spent down to avoid being over the amount allowed to have Medicaid Insurance benefits. These failures could place residents whose funds were managed by the facility at risk of losing their Medicaid insurance benefits and placed the residents' funds at risk of being misappropriated and residents/RP's not being aware of the residents' financial situation. Findings Included: Record review of Resident #3's Face Sheet (dated 09/06/24) reflected he was [AGE] year old male admitted to the facility on [DATE]. Resident #3's active diagnoses included cerebral palsy (a group of disorders that affect a person's ability to move, balance, and posture), diabetes (a chronic disease that occurs when the body doesn't produce enough insulin or can't use insulin properly, resulting in high blood sugar levels), hyperlipidemia (a condition where there are high levels of lipids, or fats, in the blood) and impulse disorder (a group of behavioral conditions that make it difficult to control your actions or reactions). Resident #3's Face Sheet reflected no legal guardian, no medical or durable power of attorney and no resident representative. Resident #3 has no legal durable power of attorney or medical power of attorney. A family member was listed as his emergency contact. Record review of Resident #3's quarterly MDS assessment dated [DATE] reflected no hearing, speech or vision issues and a BIMS score of 11, which indicated moderate cognitive impairment. Resident #3 had no symptoms of psychosis, no behavioral symptoms, no rejection of care or wandering. Record review of Resident #3's Care Plan dated 09/19/12 and last revised on 04/01/24 did not reflect he had a trust fund with the facility managing his money. The care plan also did not reflect Resident #2 had a POA or RP. (continued on next page)

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

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's Resident Statement Landscape (accounting ledger for his trust fund), reflected from 01/02/24 to present day (09/03/24), he had a running balance over $5,500 each month with the highest balance being $6,306.04 on 08/13/24 which was the last entry date. Resident #3's monthly income/credit coming in each month included a monthly credit from SSI for $30 and a monthly credit from HHSC of $45. In addition, there was a monthly interest credit of approximately $15. There had been no debits/deductions made from Resident #3's account. The date of trust fund showed it was opened on 10/16/12 and his allowance showed $0 (zero) dollars. An interview with the BOM on 08/29/24 at 2:14 PM revealed Resident #3 had no family, LAR or RP and the facility SW had been working with him to try and spend down his money before he had his Medicaid renewal. The BOM stated, We have talked to him and told him if we don't spend down, we have to send the money back to the State. She stated Resident #3 received $30 from Social Security and she thought he was a full vendor, which meant Medicaid covered whole stay. The BOM stated she thought Resident #3's friend who visited him was talked to about a burial plan. She said the friend mentioned she was wondering if they could use his money to buy him a set of encyclopedias online since he had an affinity to them. The BOM stated trust funds for residents were kept under $2,200 for Medicaid recipients or else they could lose their Medicaid eligibility. The BOM stated the risk came when it was time to renew a resident's Medicaid; if Medicaid saw that a resident was over-resourced, they may not cover the resident's stay for that month. The BOM stated, I try closer to the date on spending down, we can do different options. The BOM did not know when Resident #3's renewal date was. She stated normally she would be mailed something by the Medicaid office letting her know it was approaching. The BOM stated she sent a quarterly statement to residents and also sent them a letter when they were over-resourced. Record review of a letter titled, Resident Trust Fund Notification provided by the BOM reflected it was dated 08/29/24 and addressed to Resident #3 and stated, This letter is to notify you that your current Resident Fund balance is within $200 or exceeding what is allowable under Medical Assistance. Please contact your Social Worker within the next 7 days to discuss ways to assure continuance of Medicaid benefits. The letter had a signature line where the facility representative was supposed to sign and a signature line for the resident's acknowledgement, but neither was signed by the resident or the BOM. A follow up interview with the BOM on 08/29/24 at 2:25 PM revealed she did not actually give a Resident Trust Fund Notification to Resident #3 because he is here and we are working with him. She stated she did not have any documented evidence that Resident #3 was notified he was over-resourced. The BOM stated she was new to the position and still learning the process. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the SW on 08/29/24 at 2:41 PM revealed she had tried to get Resident #3 a computer but he did not want one. Items that he did want, like a set of music cd's, was the only thing he agreed to. The SW stated, He doesn't want anything, but we do need to spend his money down. She stated Resident #3's family had written him off, but he had a friend that came to visit him who the SW reached out to about the situation. The SW stated she asked his friend if she would purchase items for him and then could be re-imbursed out of his trust and the friend said okay. The SW stated, I would purchase but I don't want it to look like I am dabbing in his money. She stated Resident #3 was a [NAME] (a person who has an exceptional aptitude in one particular area, despite having significant impairment in other areas of intellectual or social functioning) and had a child-like mind. The SW said he can read and remembered everything. The SW stated she was his ambassador so would see him every morning rounding and he would always want her to print off a Wikipedia page of whatever topic he had previous talked to her about wanting to know. The SW stated she was not responsible for keeping track of Medicaid renewals, so she did not know how long there was until Medicaid was aware he was over-resourced. She stated Resident #3 would tell her he did not want much. She stated he did not understand the concept of spending down. The SW stated, I was thinking a new cd player to go with the cd's, but it is a drop in the bucket. The SW stated the BOM had notified her several months ago of the need to spend his trust fund money and the SW had reached out to the family and a friend of the resident, but that friend had not done anything to help spend down his money. The SW stated, I am responsible for spend downs and she [BOM] will help me. The SW stated the danger of Resident #3 carrying a balance over $6,000 was that he could lose his Medicaid benefits. An interview with Resident #3 on 09/03/24 at 11:17 AM revealed he was in his bed and was resistant to being interviewed. When asked about the facility's communication with him about his trust fund balance being over resourced, he stated they had talked to him but he was waiting on his music order to come in. He stated it was the Greatest Hits of the 70's box set of 3 CDs. He did not want to discuss his finances and was perseverating on his waiting for the CDs to arrive and that he wanted to talk to the BOM. Resident #3 stated he needed his birth certificate because the previous facility he lived at lost it. He said he did not need a new television because he already had one in the closet. An observation of Resident #3's room on 09/03/24 at 11:20 AM reflected he did not have many personal possessions. There was a small television hung (approximately 30 inches) on his wall and another smaller television (approximately 25 inches) stored in his closet. He did not have any decorations in his room or a large amount of clothing available. An interview with the DON on 09/03/24 at 3:13 PM revealed it was important to keep a resident's resource limit under the required amount because they could lose their Medicaid benefits and not qualify for a stay and then they would not get the proper care. An interview with the ADM on 09/03/24 at 4:17 PM revealed there should be oversight with the resident trust funds and what the ADM had been told was that Resident #3 refused to spend his money. The ADM stated, What I would do is notify him that this will affect his eligibility upon renewal. The ADM stated it was important to keep a resident under the required Medicaid limit because if not, the resident could be deemed ineligible for continued Medicaid coverage. The ADM stated he did not know who notified a resident when they were over-resourced and needed to spend down. He stated the BOM was in charge of the spend down process. He was not sure how often the facility audited trust funds to ensure they are managing the residents' fund appropriately. If a resident did not have a LAR or RP but also was not alert and oriented to make purchasing decisions, the ADM said he would start with the local Ombudsman and see about facilitating a guardianship for that resident. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Resident Trust Fund Policies revised 07/06 (no year given), reflected, Policy: Resident Trust Fund Policies that must be followed by all facilities are stated below. Strict adherence to these policies and procedures is necessary to comply with the State and Federal Regulations. Procedure . 17. Fund Reconciliation-The resident trust fund must be reconciled monthly. The completed reconciliation must be reviewed by the Administrator and approved to indicate the following: -The review was completed by the Administrator; -The account balance is correct. The Reconciliation Report should be sent to the Regional Financial Consultant with the following documents attached: Copy of the Bank Statement, Open Balance Report from the Trust Fund system. Once the Trust Fund Reconciliation is approved and verified by the Regional Financial Consultant: The Regional Financial Consultant must send a copy of the reviewed and approved Reconciliation to the AR Manager by the end of the month .20. Medicaid Resource-A. The resident/resident's representative must be notified when: -The amount in the resident's account reaches $200.00 less than the Medicaid resource limit for one person; B. If no resident/resident's representative is available to notify: The facility Trust Fund Monitor must notify the facility Social Services Department to verify burial needs and other needs that the resident might have. Note: The amount in the resident's account, in addition to the value of the resident's non-exempt resources, must not reach the Medicaid resource limit for one person.

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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** 33552 Based on interview and record review, the facility failed to complete a discharge summary that included, (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results; (ii) A final summary of the resident's status; (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter) for one (Residents #6) of two residents reviewed for discharge planning. The facility failed to complete a discharge summary for Resident #6 when she had a planned discharge home. This failure could place residents at risk of a recapitulation of the stay being unavailable to help ensure continuity of care once they went back home. Findings included: Record review of Resident #6's quarterly MDS assessment dated [DATE] reflected she was a [AGE] year old female who admitted to the facility on [DATE]. Resident #6 had no hearing, speech or vision issues, she was sometimes able to make herself understood and sometimes understood others. Resident #6's BIMS score was 06, which indicated severe cognitive impairment. She had no behaviors, rejection of care or wandering. Resident #6 had a feeding tube and a mechanically altered diet. Active discharge planning was not occurring at the time of the MDS assessment, and the resident did not indicate she wanted to return to the community. Record review of Resident #6's care plan dated 06/09/23 reflected the following focus areas: -[Resident #6] has a communication problem related to Dx's of aphasia and dysphagia -[Resident #6] has an ADL Self Care Performance Deficit r/t Dx: Hemiplegia and Hemiparesis (both conditions that cause weakness or paralysis on one side of the body) following Cerebral Infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it) affecting left non dominant side -[Resident #6] has a diagnosis of diabetes and is at risk for unstable blood sugars and abnormal lab results. -[Resident #6] is NPO and at risk for nutritional & hydration risk related to aphasia -[Resident #6] has unplanned/unexpected weight loss r/t Poor food intake -[Resident #6] requires the use of a feeding tube and is at risk for aspirations, weight loss, and dehydration. Feeding tube is related to: dysphagia, not eating enough to meet daily nutritional requirements. every 4 hours start enteral feeding. Formula: Glucerna 1.5; Give 240ml bolus (a single dose of a drug or other medicinal preparation given all at once). (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-[Resident #6 has hypertension and is at risk for fluctuations in blood pressure. -RESOLVED: Intravenous (IV) Therapy: [Resident #6] requires intravenous therapy and is at risk for site infiltration, infection, fluid overload, pain, and other potential complications. [Resident #6] has a peripherally inserted intravenous access site. -[Resident #6 is on Antibiotic Therapy r/t infection UTI Cefuroxime 500mg BID x 2 days - resolved -Discharge Plans, LTC: [Resident #6] is in the facility for long-term care placement as a result of a continued need for the services of skilled nursing staff as evidenced by an inability to provide selfcare and discharge planning is not needed. Record review of Resident #6's clinical chart reflected no evidence of a discharge summary. Record review of a progress note written by SW dated 07/23/24 reflected, SW received a call from [family member], she would like to discharge [Resident #6] and take her home with her. She informed SW PT would require a hospital bed, wheelchair and Hoyer lift. She [sic] notified team and ordered the DME requested. Discharge scheduled for 07/30/24. Record review of Resident #6's progress note written by LVN A dated 08/08/24 reflected, Resident discharged this shift home with home health services. [Family] here to pick up resident, all personal belongings taken with resident. Discharge paperwork given to family member, [family member] educated in each medication along with residents g-tube feeding. Family member understood without concerns at this time. An interview with LVN A on 09/03/24 at 2:13 PM revealed when a resident discharged home, the charge nurse was responsible to give the resident their medications and document in the online e-chart under the discharge paperwork section or complete a nursing progress note saying the discharge had occurred, medications given and education given on medications. LVN A stated the charge nurse who completed the discharge would be required to complete the nursing section of the discharge summary and if they could not complete it on their shift, the oncoming nurse on the next shift could finish it. LVN A stated a discharge summary was required when a resident went home because, We have to do it because it helps us know the progress a resident made from when they got here until their discharge. An interview with LVN E on 09/03/24 at 12:20 PM reflected if he was the charge nurse working at the time of a resident's discharge, he would be responsible for completing the discharge summary and then the other facility departments would complete their sections and the DON would review for completion and accuracy. An interview with the DON on 09/03/24 at 3:13 PM revealed when a resident discharged from the facility home, the charge nurse was required to complete a discharge summary. She stated it was important because, I think it helps with continuity of care when they leave, so their primary [physician] knows what is going on, what medications have been added or taken away and it gives the resident a peace of mind. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with ADON B on 09/03/24 at 3:57 PM revealed when a resident discharged home, the charge nurse completed the nursing portion of the discharge summary and they go over medications, education, what side effects to watch out for and what condition the resident left the facility in. ADON B stated a discharge summary was required when a resident went home because, If something should happen when you get home and family says I was never told this, so you have receipts and then I have then sign on the bottom on the med sheet and H&P and ask if they have any questions and we watch them transfer in and out of the car. Review of the facility's policy titled, Transfer and Discharge (including AMA) dated 10/24/22 reflected, .14. Anticipated Transfers or Discharges - resident-initiated discharges b. A member of the interdisciplinary team completes relevant sections of the Discharge Summary. The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes, but not limited to, the following: i. A recap of the resident's stay that includes diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology and consultation results. ii. A final summary of the resident's status. iii. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter). iv. A post discharge plan of care that is developed with the participation of the resident, and the resident's representative(s) which will assist the resident to adjust to his or her new living environment. c. Orientation for transfer or discharge must be provided and documented to ensure safe and orderly transfer or discharge from the facility, in a form and manner that the resident can understand. Depending on the circumstances, this orientation may be provided by various members of the interdisciplinary team .e. The comprehensive, person-centered care plan shall contain the resident's goals for admission and desired outcomes and shall be in alignment with the discharge .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on 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 two (Residents #7 and #9) of eight residents reviewed for medications and pharmacy services. 1. The facility failed to take Resident #7's blood pressure and administer her medication in accordance with the physician orders. Resident #7 was not administered Metoprolol Tartrate (beta blocker to treat high blood pressure) on 08/20/24, 08/21/24 and 08/28/24 due to her blood pressure being out of parameters. However, there was no documented evidence to indicate her blood pressure was taken in her clinical record to validate the medication was not warranted. 2. The facility failed to take Resident #9's blood glucose and administer his sliding scale insulin Novolin in accordance with the physician orders. Resident #9 was did not have his blood glucose checked and documented on the MAR nor his insulin administered if needed, 28 times in August 2024. The MAR was blank with no vitals or insulin documented as administered. The failure could place residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician and a potential for decreased health status, including low and high blood pressure, hyperglycemia, falls, disorientation and physical discomfort. Findings included: 1. Record review of Resident #7's Face Sheet dated 08/29/24 reflected she was a [AGE] year old female who admitted to the facility on [DATE]. Resident #7's active diagnoses included essential hypertension (a chronic condition where the pressure in your arteries is consistently high), Alzheimer's disease (A type of brain disorder that causes problems with memory, thinking and behavior), dysphagia (difficulty swallowing), cognitive communication deficit (a difficulty with communication that's caused by a disruption in cognition) and diabetes (a chronic disease that occurs when the body doesn't produce enough insulin or can't use insulin properly, resulting in high blood sugar levels). Record review of Resident #7's annual MDS assessment dated [DATE] reflected a BIMS score of 07, which indicated severe cognitive impairment. Resident #7 did not have a history of rejection of care during the 7-day look back assessment period. Record review of Resident #7's care plan initiated on 12/27/23 and last revised 02/02/24 reflected in part, [Resident #7] has hypertension and is at risk for fluctuations in blood pressure. Intervention: Administer antihypertensive medications as ordered. Record review of Resident #7's September 2024 Physician Orders reflected she was prescribed Metoprolol Tartrate Oral Tablet 25 MG once in the morning related to essential hypertension- Hold if SBP<100 DBP <60 Pulse <60 (Start Date 10/18/23). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #7's August 2024 MAR reflected no blood pressure reading or metoprolol tartrate administered on 08/20/24, 08/21/24 and 08/28/24. The MAR only reflected on those administration times the number 4 which the key reflected meant the resident's vitals were out of parameters. Record review of Resident #7's nursing progress notes and e-MAR medications administration notes on 08/20/24, 08/21/24 and 08/28/24 reflected no blood pressure readings to validate the blood pressure medication was not needed. During the time frame of the medications not given (over the eight day period), Resident #7 sustained two falls, one on 08/21/24 and one on 08/26/24. Both falls were unwitnessed and occurred in Resident #7's room where she was found on the floor mat each time. Resident #7 was assessed by the charge nurse and no injuries were noted. Record review of Resident #7's vitals recorded on the e-chart reflected under the Vitals Tab reflected no recorded blood pressure readings on 08/20/24. On 08/21/24, she had the following documented blood pressure readings: 137/76 at 3:36 PM, 137/76 at 3:38 PM, 131/72 at 9:30 PM, 128/76 at 9:45 PM, 130/71 at 10:00 PM, 127/70 at 10:30 PM, 127/73 at 11:02 PM and 186/78 at 12:00 AM (midnight). On 08/28/24, she had the following blood pressure readings: 122/69 at 6:43 AM, 132/90 at 10:30 AM and 133/74 at 8:43 PM. All blood pressure readings recorded on the dates where Resident #7 was not administered her metoprolol tartrate indicated her blood pressure was not out of parameters and she should have been administered the medication as prescribed. Only one blood pressure was recorded in the morning on 08/28/24 which was when Resident #7 was supposed to be administered her blood pressure medication and her blood pressure was within parameters, however, it was not administered. 2. Record review of Resident #9's Face Sheet dated 08/29/24 reflected he was an [AGE] year old male who admitted to the facility on [DATE]. Resident #9's active diagnoses included Alzheimer's disease (a progressive brain disorder that affects memory, thinking, and language), Type 2 Diabetes Mellitus with diabetic neuropathy (Diabetic neuropathy is a type of nerve damage that can occur in people with type 2 diabetes) , drug-induced hypoglycemia without coma (low blood sugar), hypertensive heart and chronic kidney disease (a condition that occurs when the kidneys are damaged and can't filter blood properly) with heart failure and long-term use of insulin. Record review of Resident #9's care plan initiated 05/02/24 and revised on 08/13/24 reflected, [Resident #9] has a diagnosis of diabetes and is at risk for unstable blood sugars and abnormal lab results. Interventions: Administer diabetic medications as ordered by the physician. Monitor for adverse reactions and report abnormals as detected, Monitor blood Sugar as ordered by physician. Administer sliding scale insulin if ordered. For any blood sugars not within the acceptable parameters as dictated by the physician, document and notify the physician. Record review of Resident #9's September 2024 Physician Orders reflected he was prescribed Novolin Flex R FlexPen Injector 100 UNIT/ML: Inject as per sliding scale: if 200 - 249 = 2 units; 250 - 299 = 4 units; 300 - 349 = 6 units; 350 - 399 = 8 units; 400 - 449 = 10 units, subcutaneously before meals and at bedtime for Diabetes (Start Date 05/15/24). Review of Resident #9's August 2024 MAR reflected no blood glucose recorded or sliding scale insulin administered on 08/03/24 (7am and 11am), 08/04/24 (4pm and 9pm), 08/08/24 at 9pm, 08/09/24 and 08/10/24 (all four administrations each day), 08/13/24 at 9pm, 08/17/24 for all four administrations, 08/18/24 (7am and 11am), 08/20/24 at 9pm, 08/22/24 (4pm and 9pm), 08/24/24 at 9pm, 08/25/24 (7am and 11am), 08/26/24 at 9pm and 08/28/24 (4pm and 9pm). On the other dates in August 2024, Resident #9's highest blood glucose reading was 425 and the lowest was 96. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #9's nursing progress notes and e-MAR medications administration notes for August 2024 reflected no blood glucose readings to validate the sliding scale insulin was not needed. 3. An interview with LVN A on 09/03/24 at 11:23 AM revealed when there were blanks on the residents' MAR, it may have meant that the medication was not applicable or the resident refused. He stated there should always be a reason why it was not administered reflected in the nursing progress notes. LVN A stated it was important to document if a resident was administered a medication or not because it helps show any trends forming, such as refusals or changes in vitals. When a medication required a blood pressure reading to be taken, LVN A stated it was important to take the vital before administering the medication, Because if someone already has high blood pressure and the medication raises, we don't want to give it, so there are certain parameters. Sometimes meds can bring it (blood pressure) up or bring it down. LVN A did not know who reviewed the MARs to ensure they were completed accurately. An interview with LVN E on 09/03/24 at 12:20 PM revealed when there is a blank on the MAR, it indicated the medication was not administered. He stated it was important to show the administration of a medications was completed as ordered and if it was not done, the doctor and family should be notified and there should be a nursing progress note to indicate why it was not given. LVN E stated it was important to take a resident's blood pressure or blood glucose reading prior to mediations administration so that the resident did not bottom out, which he stated meant they could go into cardiac arrest. LVN E stated the medications administration records were reviewed by the two ADONs to ensure they were completed and medications/vitals being taken/given as ordered. An interview with the DON on 09/03/24 at 3:13 PM revealed when there were blanks on the MAR, it indicated that the medication was not administered and the vital was not taken. The DON stated it was important to document a medication administration because it showed that the nurse was following physician's orders and to show it was done on the nurse's shift and at the time it was scheduled to be given. When a medication required a blood pressure to be taken, the DON stated it was important to take the vital before administering the medication because of the parameters, You don't want to give it if too low or too high, you have to notify the doctor, you do not want to give a medication that will increase or decrease the resident's vitals. The DON stated the ADONs were responsible as well as herself, to monitor the residents' MAR to ensure medications were given as ordered. She stated that audit was done weekly and if they saw discrepancies, they would go to the nurse who worked that shift to see why the medication/vital was not documented. (continued on next page)

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Advanced Health & Rehab Center of Garland	1201 Colonel Drive Garland, TX 75043

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Medication -Treatment Administration and Documentation Guidelines revised 04/06/2023, reflected, Anticipated Outcome- To provide a process for accurate, timely administration and documentation of medication and treatments; Process-1. Verify labels accurately reflect the physician orders on the Electronic Medication Administration Record (EMAR) and Electronic Treatment Administration Record (ETAR) prior to administering patient medications and treatments. 2.Verify administration accuracy by checking the medication with the EMAR three (3) times. 3.Verify and provide medication or treatment focused assessment i.e. BP, wound measurements as indicated by manufacturers guidelines or physician orders. 4.Administer the medication according to the physician order. 5.Document e- signature for medications and treatments administered on the EMAR or ETAR immediately following administration .7. Medications or treatments that were not administered should be documented as not administered on the EMAR/ ETAR with the reason for not administration . 12. Review the EMAR and ETAR after each medication and treatment administration is completed and prior to the end of the shift to validate documentation is completed and supports services provided according to physician orders. 13.Document omission or held medication and treatments on the 24 Hr. Report (CMA and Licensed Nurse). 14.Complete a Medication Error Report for medication administration discrepancies. 15.Provide a summary of medication or treatment administration issues to on-coming charge nurse or CMA during shift-to-shift report.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on interview and record review, the facility failed to provide or obtain laboratory services to meet the needs of its residents and failed to be responsible for the quality and timeliness of the services for one (Resident #1) of eight residents reviewed for labs. The facility failed to complete Resident #1's lab order for C-diff (a bacterium that can cause diarrhea and inflammation of the colon, also known as colitis) as ordered by the physician. The failure could place residents at risk for delays in the provision of treatment for laboratory abnormalities and acute exacerbation of clinical conditions. Findings included: Record review of Resident #1's Face Sheet dated [DATE] reflected he a [AGE] year old male who admitted to the facility on [DATE] and readmitted after a brief hospital stay on [DATE], and then died on [DATE] in the facility. Resident #1 had active diagnoses which included sepsis (onset date of [DATE]) (a life-threatening condition that occurs when the body has an extreme response to an infection, damaging tissues and organs), oral dysphagia (difficulty swallowing), dementia (a general term for a loss of cognitive abilities that affects a person's ability to think, remember, and reason), obstruction of bile duct (occurs when the bile ducts, which transport bile from the liver to the small intestine, are blocked), neuromuscular dysfunction of the bladder (a condition that affects bladder control due to damage to the nervous system), hypertension (a chronic condition where the pressure in your arteries is consistently high), atrial fibrillation (a type of irregular heartbeat that occurs when the upper chambers of the heart beat abnormally) and metabolic encephalopathy (a brain dysfunction that occurs due to a chemical imbalance in the blood). Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected he had a BIMS score of 15, which indicated no cognitive impairment. Resident #1 has no signs or symptoms of delirium, no psychosis, no verbal or physical behaviors and no wandering or rejection of care. Resident #1 did have an elevated mood severity score of 14 which indicated he had problems with depression, poor appetite, trouble with concentration, sleeping issues and feeling like his movements were too fast/slow. Resident #1 had range of motion impairment on one side of his upper extremity and used a wheelchair for mobility. Resident #1 was dependent on staff for toileting to include the ability to maintain perineal hygiene and he was dependent on staff for showers/bathing. Resident #1 had an indwelling catheter and was frequently incontinent of bowel. Resident #1 had seven unstageable pressure injuries presenting as deep tissue injuries present upon admission and two venous and arterial ulcers present which required pressure ulcer/injury care, surgical wound care and application of nonsurgical dressings. Resident #1 was administered a high risk medication of an antibiotic. Record review of Resident #1's care plan dated [DATE] reflected: (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-[Resident #1] is incontinent of bowel/bladder related to decreased mobility; Goal- [Resident #1] will be clean and odor free through next review date; Intervention- Check frequently for wetness and soiling, and change as needed, Monitor for and report to MD s/sx UTI: pain, burning, blood tinged, urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. -[Resident #1] is on Antibiotic Therapy r/t infection UTI/Sepsis - Augmentin BID x 10 days - resolved ([DATE]); Interventions- [Resident #1] will be free of any discomfort or adverse side effects of antibiotic therapy through the review date, Any antibiotic may cause diarrhea, nausea, vomiting, anorexia, and hypersensitivity /allergic reactions. Monitor q-shift for adverse reaction. Record review of Resident #1's nursing progress note dated [DATE] reflected, This nurse was notified by staff about resident having strong odor during bowel movement. Action: This nurse notified Dr about situation, new order for stool culture for possible C. Diff. Response: Stool culture collected this shift. Record review of Resident #1's physician order dated [DATE] reflected an order for a stool culture. Review of Resident #1's clinical chart revealed no evidence of a lab collection for C.Diff or a lab result for C. Diff from [DATE] through [DATE]. Record review of Resident #1's MAR from [DATE] through [DATE] reflected his vitals were within normal limits during the medication administration passes. Record review of Resident #1's nursing progress notes from [DATE] through [DATE] did not reflect any further issues with Resident #1's stool/bowel movements. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with LVN A on [DATE] at 11:23 AM revealed he had been the charge nurse for Resident #1 during his stay at the facility on the morning/afternoon shifts. He stated Resident #1 admitted with a number of medical issues and over time began to decline, get infections and became more confused. LVN A stated he remembered someone coming to tell him one day that Resident #1 had a foul smell coming from his bowel. When LVN A went to assess Resident #1, LVN A stated it seemed more like diarrhea to him versus C. Diff. He stated C. Diff had a certain smell and texture like sticky jello and tended to be yellowish/green, which Resident #1 did not present with. However, he still notified the doctor and got an order for a C.Diff test. LVN A stated the facility had a small vial he collect Resident #1's stool in and he left it in the Nurses' Station 2 fridge. LVN A stated the lab tech usually came around 2 in the morning every night to collect labs and specimens and the charge nurse who got the order for the lab would usually leave a note or tell them, They know to check the fridge. LVN A stated, however, that the fridge was not always checked for specimens that were collected depending on who the lab tech was coming in that night. LVN A stated once a specimen was collected by the charge nurse, the responsibility then fell on the lab company to come out and collect it. He stated the lab requisition binder was supposed to be updated by the charge nurses for the lab order, then when the lab tech came in to the facility each night, the tech checked the lab binder, made a copy of who needed a lab and who had a collection to pick up and proceeded to do their labs. LVN A stated the lab requisition forms for [DATE] were no longer in the binder and he did not know who had them. LVN A stated he was sure he put Resident #1's specimen in the fridge and the lab company came after his shift was over. He stated for a fecal specimen, it was good for about 24 hours in the fridge before it would start growing bacteria on it and give inaccurate results. LVN A stated if a resident was showing signs/symptoms of C.diff and did not get treated for it promptly, an infection could occur, but it would not be life-threatening. He stated it was important to get a physician ordered lab completed, To make sure we know exactly which pathogen he has with C.diff and treat with a specific antibiotic. An interview with the DON on [DATE] at 3:13 PM revealed when a resident had an order for C.diff, her expectation was that the charge nurse collected the specimen, then sent in a requisition form to the lab company via fax or phone, and put the order in the facility's lab requisition book. Then the lab company came to the facility, checked the lab requisition book and picked up the specimen. The DON stated there was only one fridge in the facility where residents' specimens were kept, but there were lab requisition books on each nurses' station. She stated the nursing management was supposed to check with the charge nurses to make sure the specimen had been picked up, and the charge nurse was supposed to write a progress note and document on the 24-hour log throughout the process for oncoming shift to follow up. The DON stated she had already been in contact with the lab company after investigator intervention and no one could figure out what happened or why the lab was not completed. Record review of the facility's policy titled, Radiology and other Diagnostic Services and Reporting, revised [DATE], reflected, Policy: The facility must provide or obtain radiology and other diagnostic services when ordered by a physician, physician assistant; nurse practitioner or clinical nurse specialist in accordance with state law . 1. The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents .4. Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside the clinical reference range .6. All radiology and other diagnostic service reports will be dated and contain the name and address of the testing laboratory and will be filed in the resident's clinical record.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on interview and record review, in accordance with accepted professional standards and practices, the facility failed to maintain medical records on each resident that are complete; accurately documented; readily accessible; and systematically organized for two (Resident #4 and Resident #5) of four residents reviewed for pressure ulcers and non-pressure wounds. 1. The facility failed to document wound care was provided for Resident #4 in August 2024 on 29 occasions. 2. The facility failed to document wound care was provided for Resident #5 in August 2024 on 36 occasions. The facility failure could place residents at risk of not receiving wound care, wounds worsening and a lack of oversight of their clinical records by the nursing staff and nursing management. Findings included: 1.Record review of Resident #4's Face Sheet dated 08/29/24 reflected he was a [AGE] year old male who admitted to the facility on [DATE]. Resident #4's active diagnoses included in part, quadriplegia (paralysis of all four limbs), cellulitis of right lower limb (a bacterial infection that affects the skin's deeper layers, including the dermis and subcutaneous fat), diabetes (a chronic disease that occurs when the body doesn't produce enough insulin or can't use insulin properly, resulting in high blood sugar levels), disorder of the skin and subcutaneous tissue, gangrene (a serious condition that occurs when tissue in the body dies due to a lack of blood supply), pressure ulcer of sacral region, acquired absence of right leg above knee and colostomy status (a surgical procedure that creates an opening in the large intestine, or colon, through the abdominal wall). Record review of Resident #4's quarterly MDS assessment dated [DATE] reflected a BIMS score of 15, which indicated no cognitive impairment. Resident #4 had no rejection of care issues. Resident #4 was at risk of developing pressure ulcers/injuries and had one stage 4 pressure ulcer at the time of the assessment that was not present upon admission to the facility. Resident #4 also had skin tears and moisture-associated skin damage and required application of non-surgical dressings and applications of ointments/medications. Record review of Resident #4's care plan dated 02/11/20 and last revised 08/29/24 reflected the following care areas: 1) Problem: [Resident #4] has a wounds to the Left lateral shin, sacrum (a large, triangular bone that forms the base of the spine and the center of the pelvis), left lateral foot, right upper back, right ischium (a thick, irregularly shaped bone that's part of the hip bone, along with the ilium and pubis) and is at increased risk for infection and pain. Interventions: Provide wound care per physician's order. 2) Problem: [Resident #4] has documented skin issues. Interventions: Provide wound care per physician's order. Record review of Resident #4's current September 2024 physician's orders reflected: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-NON-PRESSURE WOUND OF THE LEFT ISCHIUM: Cleanse area with normal saline or wound cleanser apply Vaseline gauze, cover with ABD pad daily every day shift for Wound Care -Start Date-07/17/2024-D/C Date-08/13/2024 - NON-PRESSURE WOUND OF THE RIGHT ISCHIUM: Cleanse area with normal saline or wound cleanser apply Vaseline gauze, cover with ABD pad daily every day shift for Wound Care -Start Date- 07/17/2024 - NON-PRESSURE WOUND OF THE RIGHT UPPER BACK: Cleanse wound with normal saline or wound cleanser pat dry apply collagen powder and cover with gauze island w/bdr daily. Every day shift for Wound Care -Start Date- 07/24/2024 -D/C Date- 08/21/2024 - STAGE 3 PRESSURE WOUND TO THE SACRUM: Cleanse wound with normal saline or wound cleanser pat dry apply Vaseline gauze and cover with ABD pad daily every day shift for Wound Care -Start Date- 07/17/2024 - STAGE 4 PRESSURE WOUND OF THE LEFT LATERAL SHIN: Cleanse area with normal saline or wound cleanser apply collagen sheet with alginate calcium and cover with ABD pad gauze roll with kerlix (a brand of bandage rolls made of 100% cotton gauze that are designed to protect and cushion wounds) daily and as needed every day shift for Wound Care -Start Date- 05/09/2024 - UNSTAGEABLE DTI OF THE LEFT LATERAL FOOT: Cleanse wound with normal saline, pat dry apply skin prep daily every day shift for Wound Care -Start Date- 08/10/2024 -D/C Date- 08/21/2024. Record review of the last wound care visit for Resident #4 on 08/28/24 reflected a wound care evaluation and assessment was performed and five focused wound exams were completed. -Site 1- Non-pressure wound over 224 days duration of the right, upper back full thickness, wound measurements were 1.0 x 0.2 x 0.4 cm, wound progress was not at goal. -Site 2 - Non pressure wound over 120 days duration of the right ischium partial thickness, wound measurements 4.0 x 3.0 x 0.1 cm, wound progress had improved as evidenced by decreased surface area. -Site 3- Stage 4 pressure wound of the left, lateral skin full thickness over 113 days duration, wound size 6.0 x 1.5 x 0.1 cm, wound progress was not at goal. (Measurements noted by the clinician to be the same as the previous visit) -Site 4- Stage 3 pressure wound sacrum full thickness over 70 days duration, wound size 4.0 x 8.0 x 0.1 cm, wound progress was not at goal. -Site 5- Stage 3 pressure wound of the left, lateral foot full thickness over 21 days duration, wound size 0.2 x 0.6 x 0.1 cm, wound progress improved as evidenced by decreased surface area per clinician. Record review of Resident #4's August 2024 TAR reflected the following treatments were blank and not documented as completed: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Non-pressure wound of the left ischium- Cleanse area with normal saline or wound cleanser apply Vaseline gauze, cover with ABD pad daily every day shift for Wound Care on 08/01/24, 08/02/24, 08/05/24 and 08/10/24. -Non-pressure wound of the right ischium- Cleanse area with normal saline or wound cleanser apply Vaseline gauze, cover with ABD pad daily every day shift for Wound Care on 08/01/24, 08/02/24, 08/05/24, 08/10/24 and 08/13/24. -Non-pressure wound of the right upper back- Cleanse wound with normal saline or wound cleanser pat dry apply collagen powder and cover with gauze island with border daily every day shift for Wound Care on 08/01/24, 08/02/24, 08/05/24, 08/10/24 and 08/13/24. -Stage 3 pressure wound to the sacrum- Cleanse wound with normal saline or wound cleanser pat dry apply Vaseline gauze and cover with ABD pad daily every day shift for Wound Care on 08/01/24, 08/02/24, 08/05/24, 08/10/24 and 08/13/24. -Stage 4 pressure wound of the left lateral shin- Cleanse area with normal saline or wound cleanser apply collagen sheet with alginate calcium and cover with ABD pad gauze roll with kerlix daily and as needed every day shift for Wound Care on 08/01/24, 08/02/24, 08/05/24, 08/10/24 and 08/13/24. -Unstageable DTI of left lateral foot- Cleanse wound with normal saline, pat dry apply skin prep daily every day shift for Wound Care on 08/10/24 and 08/13/24. Record review of Resident #4's clinical chart, to include nursing progress notes, did not document or indicate why the wound care was not performed on the numerous dates. 2. Record review of Resident #5's Face Sheet dated 08/29/24 reflected he was a [AGE] year old male who admitted the facility on 07/13/23. Resident #5's active diagnoses included, in part, paraplegia (Paralysis that affects all or part of the trunk, legs, and pelvic organs), ileostomy status (a surgical procedure that creates an opening in the abdomen to divert waste from the body through the small intestine instead of the large intestine), peripheral vascular disease (a condition that occurs when blood vessels narrow or become blocked, reducing blood flow to the body), atherosclerosis of native arteries of right leg with ulceration on heel and midfoot (a vascular disease that causes arteries to thicken, harden, and lose elasticity), unspecified open wound lower leg and acquired absence of left toe(s). Record review of Resident #5's annual MDS assessment dated [DATE] reflected a BIMS score of 12, which indicated moderate cognitive impairment. Resident #5 did not have any rejection of care issues. Resident #5 had range of motion impairment on both sides of his lower extremities and used a wheelchair for mobility. Resident #5 was at risk of developing pressure ulcers/injuries, had a stage four pressure ulcer upon admission, one venous/arterial ulcer present, open lesions on the foot, surgical wounds and skin tears. Resident #5 required pressure ulcer/injury care, surgical care, application of non-surgical dressings and applications of dressings to feet. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's care plan dated 08/02/24 and last revised on 08/29/24 reflected, Non pressure wound: [Resident #5] has a non-pressure wound to his right lateral ankle. Intervention: Monitor and document for signs and symptoms of infection such as foul-smelling drainage, redness, swelling, tenderness, fever, and red lines or streaking originating at the wound. Notify the physician when detected. Record review of Resident #5's current September 2024 physician's orders reflected, Non-pressure wound of the right lateral ankle- Cleanse wound with normal saline or wound cleanser pat dry apply collagen powder and cover with hydrocolloid sheet (satin) once weekly every day shift every Wednesday for Wound Care (Start Date 08/21/24); Stage 4 pressure wound of the left ischium: Cleanse wound with normal saline or wound cleanser pat dry apply xeroform gauze and cover with gauze island w/bdr daily every day shift for Wound Care (start date 07/31/24). Orders related to the previous wound care orders reflected: -NON-PRESSURE WOUND OF THE RIGHT LATERAL ANKLE: Cleanse wound with normal saline or wound cleanser pat dry apply hydrocolloid sheet (satin) once weekly every day shift every Wed for Wound Care -Start Date-08/14/2024 -D/C Date-08/21/2024 -NON-PRESSURE WOUND OF THE LEFT LATERAL ANKLE: Cleanse wound with normal saline or wound cleanser pat dry, apply collagen powder and cover with gauze island w/bdr daily every day shift for Wound Care -Start Date- 07/24/2024-D/C Date- 08/14/2024 NON-PRESSURE WOUND OF THE RIGHT HIP: Cleanse wound with normal saline or wound cleanser pat dry, apply collagen powder and cover with gauze island w/bdr daily every day shift for Wound Care -Start Date- 07/24/2024-D/C Date-08/02/2024 NON-PRESSURE WOUND OF THE RIGHT LATERAL FOOT: Cleanse wound with normal saline or wound cleanser pat dry, apply collagen sheet and cover with gauze island w/bdr daily every day shift for Wound Care -Start Date- 07/24/2024-D/C Date- 08/14/2024 -STAGE 4 PRESSURE WOUND OF THE LEFT ISCHIUM: Cleanse wound with normal saline or wound cleanser pat dry apply xeroform gauze and cover with gauze island w/bdr daily every day shift for Wound Care -Start Date- 07/31/2024 -UNSTAGEABLE DTI OF THE LEFT HEEL: Cleanse wound with normal saline or wound cleanser, pat dry apply skin prep daily every day shift for Wound Care -Start Date- 07/24/2024-D/C Date- 08/10/2024 - NON -PRESSURE WOUND OF THE LEFT SHIN: Cleanse wound with normal saline or wound cleanser pat dry apply xeroform gauze and cover with gauze island w/bdr daily every shift for Wound care-Start Date-08/10/2024- D/C Date- 08/28/2024. Record review of Resident #5's August 2024 TAR reflected the following treatments were blank and not documented as completed by staff initialing the TAR: -Non-Pressure wound of the left lateral ankle-Cleanse wound with normal saline or wound cleanser pat dry, apply collagen powder and cover with gauze island with border daily every day shift for Wound Care on 08/01/24, 08/02/24, 08/05/24 and 08/10/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Non-pressure wound of the right hip- Cleanse wound with normal saline or wound cleanser pat dry, apply collagen powder and cover with gauze island with border daily every day shift for Wound Care on 08/01/24. -Non-pressure wound of the right lateral foot- Cleanse wound with normal saline or wound cleanser pat dry, apply collagen sheet and cover with gauze island with border daily every day shift for Wound Care on 08/01/24, 08/02/24, 08/05/24 and 08/10/24. -Non-pressure wound of the left ischium- Cleanse wound with normal saline or wound cleanser pat dry apply xeroform gauze and cover with gauze island with border daily every day shift for Wound Care on 08/01/24, 08/03/24, 08/04/24 and 08/23/24. -Unstageable DTI of the left heel- Cleanse wound with normal saline or wound cleanser, pat dry apply skin prep daily every day shift for Wound Care on 08/01/24, 08/02/24 and 08/05/24 on the 6A-2P shift. -Non-pressure wound of the left shin- Cleanse wound with normal saline or wound cleanser pat dry apply xeroform gauze and cover with gauze island with border daily every shift for Wound Care on 08/10/24 and 08/23/24 on the 6A-2P shift, 08/10/24, 08/12/24 through 08/16/24, 08/18/24 through 08/24/24 and 08/26/24, 08/27/24 and 08/28/24 on the 2P-10P shift; and 08/10/24, 08/13/24, 08/14/24, 08/19/24, 08/20/24, 08/25/24 and 08/26/24 on the overnight shift (10P-6A). 3. An interview with LVN E on 09/03/24 at 12:20 PM revealed there was a treatment nurse (LVN F) and a weekend nurse who did the wound care for the residents. If one of them were not present in the facility to work, then the responsibility for wound care was with the charge nurse. LVN E stated it was important to follow through with wound care orders because it would help the wound to heal faster and not cause more harm to the resident. LVN E stated the blanks on the TAR for wound care could be a result of the wound care nurse not available in the facility and no one telling the charge nurses, so maybe wound care did not get done. LVN E stated, It's not like we wouldn't do it, we just don't know. An interview with the wound care nurse, LVN F on 09/03/24 at 2:53 PM revealed he was responsible for the wound care for all residents during the weekdays and there was a weekend supervisor/nurse who did wound care on the weekends. LVN F stated blanks on the MAR showing no wound care was provided could be a result of misdocumentation, or maybe the resident's wound did not change, or maybe the resident refused. He stated if a resident refused wound care he would indicate that under the date of treatment on the TAR. LVN F stated the DON was responsible for ensuring TARs were completed accurately but he did not know how often, he surmised monthly. LVN F stated it was important to follow through with wound care orders, To make sure the wounds are healing correctly and it doesn't get infected and doesn't take more time than necessary to heal. An interview with the DON on 09/03/24 at 3:13 PM revealed the facility had a wound care nurse who did wound care Monday through Friday and the weekend supervisor did wound care on Saturday/Sunday. The DON stated it was important to follow through with wound care orders, to decrease the risk of infection and to monitor the progress of the wound and make sure it is healing. If the TAR did not reflect wound care was not, then it could not be determined if it was completed. The DON stated she was not sure who audited the TAR to ensure wound care was done per orders and documented. (continued on next page)

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	455731	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health & Rehab Center of Garland	1201 Colonel Drive Garland, TX 75043

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with ADON B on 09/03/24 at 3:57 PM revealed if the TAR was blank for wound care, the nursing management would have to question the nurses to see what happened. ADON B stated the wound care nurse was responsible for auditing the resident's wound TAR for accuracy, Because he knows exactly what treatments are being done. Record review of Resident #5's clinical chart, to include nursing progress notes, did not document or indicate why the wound care was not performed on the numerous dates. 4. Review of the facility's policy titled, Skin Prevention and Management Guidelines, revised 04/13/23, reflected, Guidelines . 1. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate .

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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** 33552 Based on observation, interview and record review, the facility failed to establish and 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 one (Resident #2) of eight residents reviewed for infections. The facility failed to ensure COVID positive Resident #2, was appropriately isolated for 10 days per their facility COVID policy. On 09/03/24, Resident #2 was on day 7 of 10 in her isolation when she was in the communal dining room eating lunch at a table with residents nearby who were not wearing a mask and at risk of contracting the virus. The facility failure placed residents at risk of contracting COVID-19, which could lead to a decline in their health. Findings included: Record review of Resident #2's Face Sheet (dated 09/03/24) reflected she was a [AGE] year old female admitted to the facility on [DATE] with active diagnoses which included Alzheimer's disease (a progressive brain disorder that affects memory, thinking, and language), hypertension (a chronic condition where the pressure in your arteries is consistently high), depression (a mental disorder that can affect a person's thoughts, feelings, and ability to function), anxiety (an emotion that can feel like a state of inner turmoil, dread, or uneasiness), and dysphagia (difficulty swallowing). Record review of Resident #2's quarterly MDS assessment dated [DATE] reflected she was rarely understood and rarely understood others, had impaired vision and a BIMS score of 00, which indicated severe cognitive impairment. Resident #2 had no signs or symptoms of delirium, no negative mood issues, no indicators of psychosis or verbal/physical behaviors, no rejection of care and no wandering. Resident #1 had a range of motion impairment on one side of her lower body and used a walker for mobility. Record review of Resident #2's care plan focus area initiated on 08/23/24 reflected, Focus: Symptoms of viral respiratory infection (RSV, Influenza, COVID-19); Goal: [Resident #2] will not exhibit signs/symptoms of viral respiratory infection through next review date; Interventions: Educate Staff, Resident, family, visitors of signs and symptoms of viral respiratory infections and precautions, Encourage/ Educate resident/ resident family on vaccinations for respiratory viruses (COVID-19, Influenza, pneumonia, etc.), Observe for and promptly report signs and symptoms: fever, coughing, shortness of breath, or other respiratory issues. Record review of Resident #2's care plan did not reflect that she was COVID positive nor what interventions needed to occur as a result. Record review of Resident #2's nursing progress notes from 08/27/24 through 09/03/24 did not reflect she had issues with wandering behaviors or resistance to staying in her room during the isolation time frame. The following nursing progress notes followed her COVID diagnosis and reflected: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 08/27/24: Alert Note: Resident tested positive for covid noted resident with hoarse voice no cough or running nose noted. [Doctor] made aware no new order given [family] also notified. (e-signed by LVN C). - 08/29/24: Alert Note: Resident positive covid, no noted cough, present with hoarse voiced. No sob noted afebrile(without a fever), appetite is good and tolerated well, temp 96.3. (e-signed by LVN C) - 08/31/24: Alert Note: Day 4/10 Covid positive, asymptomatic. Afebrile. Has rested well this shift. All wants/needs anticipated and met. (e-signed by LVN D) - 09/03/24: Alert Note: Day 7/10 Covid positive; remains asymptomatic. Resting peacefully, eyes closed, respirations even/unlabored. (e-signed by LVN D) An interview with LVN C on 09/03/24 at 10:45 AM revealed Resident #2 was positive for COVID. Observation of Resident #2's bedroom on 09/03/24 at 10:50 AM reflected she was on droplet isolation precautions with signage on her door that reflected any visitors must check in with the nurse first and don put on) the proper PPE. An interview with LVN E on 09/03/24 at 12:20 PM revealed Resident #2 was positive for COVID and was required to isolate for ten days. An observation of Resident #2 on 09/03/24 at 12:55 PM revealed she was sitting in the dining room on the secured unit at a table eating lunch with no mask on next to another resident, and with approximately ten residents sitting near her at other tables. Resident #2 was not able to be interviewed about her COVID positive status or her isolation, she had limited cognition and did not understand the questions. LVN C was sitting at a table with ADON B next to Resident #2's table with other residents. There was no observation of staff redirecting Resident #2 to her room to isolate. An interview with LVN C on 09/03/24 at 12:56 PM occurred where she was queried again if Resident #2 was the resident that was positive for COVID and on isolation; she responded yes. She was asked why Resident #2 was mingling with other residents at lunch in the dining room if she was still at risk to pass the virus. LVN C stated that Resident #2 was okay and was going to be coming off isolation on 09/05/24 in a couple days and she had tested negative the past Friday (08/30/24), So she is okay. Record review of Resident #2's clinical chart did not reveal any evidence through uploaded documents, nursing or physician progress notes that Resident #2 had tested negative on 08/30/24. An interview with LVN F on 09/03/24 at 2:53 PM revealed when a resident was positive for COVID, the protocol was to move that resident into isolation and set up PPE equipment for whoever was going to be entering their room, then the resident stayed in their room for the duration of the isolation time frame. LVN F stated on the secured unit, it was hard to follow that protocol because not all of the residents were compliant. He stated, We re-guide them to their rooms, but it is hard. Sometimes we try to bring them out of the unit if they are not wanderers and do the isolation on the other side. It can be difficult because you can't restraint them because they are moving around and non-complaint. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with LVN A on 09/03/24 at 2:13 PM revealed the facility COVID isolation protocols were that a resident had to isolate for ten days when they tested positive, even if they had no symptoms. LVN A stated there were different COVID strains circulating and even though a resident may not appear sick, they could still pass the virus on to other residents and that person could have a negative impact from getting the virus. LVN A stated residents positive for COVID could not come out of isolation before their ten day time frame, That's the whole point of doing isolation, even if they wear a mask. You never know if they cough or sneeze, especially working with geriatrics, they can be very sensitive. An interview with the DON on 09/03/24 at 3:13 PM revealed residents, like Resident #2 who live in the secured unit, were difficult to keep isolated when they test positive for COVID. The DON stated, She will try to get out and say I want to go here, she likes things her way. The DON stated isolation was for a maximum of ten days and the facility did not test during the isolation time frame, We just keep them in isolation for ten days. The DON stated the risk of Resident #2 intermingling with the other residents on the secured unit while she was supposed to be on isolation could result in another resident getting COVID. An interview with the ADM on 09/03/24 at 4:17 PM revealed he needed to check the isolation facility protocols and guidelines for residents who tested positive for COVID as he was new to the facility as the ADM for three weeks. Review of the facility's policy titled, Novel Coronavirus Prevention and Response, revised January 2024, reflected, Policy: This facility will respond promptly upon suspicion of illness associated with a novel coronavirus in efforts to identify, treat, and prevent the spread of the virus, and for other causes of respiratory illness, such as influenza or other respiratory panels . 8. Procedure when COVID-19 is suspected or confirmed: .B. Place resident in a private room (containing a private bathroom) with the door closed. Follow current CDC guidance for quarantine timeframes . Implement standard, contact, and droplet precautions. Wear gloves, gowns, goggles/face shields, and a NIOSH-approved N95 or equivalent or higher-level respirator upon entering room and when caring for the resident. Restrict resident to his/her room. Place facemask on resident if leaving the room for medically- necessary activities . 12. Duration of Transmission-Based Precautions for Patients with SARS-CoV-2 Infection .D. Patients with mild to moderate illness who are not moderately to severely immunocompromised: o At least 10 days have passed since symptoms first appeared and o At least 24 hours have passed since last fever without the use of fever-reducing medications and o Symptoms (e.g., cough, shortness of breath) have improved E. Patients who were asymptomatic throughout their infection and are not moderately to severely immunocompromised: o At least 10 days have passed since the date of their first positive viral test.