STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455733	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage at Turner Park Health & Rehab	820 Small St Grand Prairie, TX 75050

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 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** 37028 Based on observations, interviews, and record review, the facility failed to ensure the resident had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 5 residents (Resident #4) reviewed for physical environment. The facility failed to ensure the call light was within reach for Resident #4. This could place the residents at risk of not receiving the care and services to maintain their highest level of well-being. Findings included: 1. Record review of Resident #4's Quarterly MDS Assessment, dated 10/16/24, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His BIMs score was 6 indicating his cognitive status was severely impaired. He had no behaviors. He required substantial/maximal assistance (Helper does more than half the effort) with transfers and toileting. His diagnoses included non-Alzheimer's dementia and seizures. Record review of Resident #4's Care Plan, dated 10/20/23, reflected the resident was at risk for falls. Facility interventions included: Make sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. An observation and interview on 01/07/25 at 10:11 AM with Resident #4 revealed he was lying in bed. His call light was not visible. The resident said it was behind the dresser and he could not reach it. He said he did not press the call light and that staff checked on him. An interview on 01/07/25 at 10:15 AM with CNA B revealed he was in the hallway. CNA B entered Resident #4's room. CNA B looked for the call light. He grabbed it from behind the dresser and put it within the resident's reach. CNA B said it was important for Resident #4 have his call light in case he needed to use it to call staff. CNA B said he checked daily to make sure the resident's call light was within reach. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 01/07/25 at 2:10 PM with RN C revealed she did not know why Resident #4 did not have access to his call light. RN C said the aides and nurses were responsible for making sure the resident had their call light within reach to contact staff. She said she made rounds every 2 hours to make sure residents had their call lights. An interview on 01/07/25 at 2:35 PM with the Administrator revealed Resident #4 lived in the Memory Care Unit and would move his call light . She said she did not know why the behavior was not care planned. An interview on 01/08/25 at 12:55 PM with the DON revealed she did not know why Resident #4 did not have access to his call light. She said staff were responsible for making sure residents had their call lights to contact staff. The DON said she had not identified it as an issue with the resident before. She said the facility was going to in-service staff to make sure residents had access to their call lights. Record review of the facility's policy titled, Resident Rights, not dated, reflected: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility .

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview, and record review, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 (Resident #1) of 3 residents reviewed for pressure ulcers. The facility failed to ensure LVN A provided physician ordered wound care for Resident #1 on 01/04/25 - 01/07/25. This failure could place residents with pressure wounds at risk of the wound worsening, leading to increased pain, infection, delayed healing, serious complications including sepsis, reduced mobility, and a lower quality of life. Findings included: Record Review of Resident 1's quarterly MDS assessment revealed he was an [AGE] year-old male, admitted to the facility on [DATE]. Resident's MDS revealed he had a BIMS score of 9 indicating his cognition was moderately impaired. His diagnoses included heart failure, peripheral vascular disease (a chronic condition that reduces blood flow to the arms, legs, and organs), end-stage renal disease, malnutrition, and traumatic amputation of most toes. Record Review of Resident #1's Care Plans reflected, 11/29/24 The resident had a pressure ulcer of the left heel. Facility interventions included: Document on pressure ulcer of the left heel, amount of drainage, peri-wound area, pain, edema, and circumference measurements. Evaluate wound for: size, depth, margins: peri-wound skin. Document progress in wound healing on an ongoing basis. Notify physician as indicated. There was no care plan for the right heel. Record Review of Resident #1's Order Summary Report, dated January 2025, reflected: 1. Cleanse wound to left heel with normal saline, pat dry, apply betadine, and cover with a gauze roll (kerlix), and secure with tape (paper) once daily and as needed for wound care. 2. Cleanse wound to right heel with normal saline, pat dry, apply collagen powder and calcium alginate, cover gauze roll (kerlix), and secure with tape (paper) once daily one time a day for wound care. 3. May have pressure relieving mattress every shift. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's Wound Evaluation and Management Summary reflected: 01/01/25 1. Stage 4 Pressure Wound of the Right Heel: 1.5 x 0.5 x Not Measurable Centimeters with black necrotic (dead) tissue. Wound progress: Exacerbated (worsened) 2. Unstageable Wound of the Left Heel: 0.9 x 0.8 x Not Measurable Centimeters with black necrotic tissue. Wound progress: Improved 01/08/25 1. Stage 4 Pressure Wound of the Right Heel: 1 x 0.5 x Not Measurable centimeters with black necrotic tissue. Wound progress: Improved 2. Unstageable Wound of the Left Heel: 0.8 x 0.8 x Not Measurable Centimeters with black necrotic tissue. Wound progress: Improved Record review of Resident #1's electronic treatment administration record reflected LVN A documented the ordered wound care was completed on 01/04/25-01/07/25. An observation and interview on 01/07/24 at 9:50 AM with Resident #1 and his family member revealed he was lying in bed. He was awake, alert, oriented. His feet were uncovered and lying flat on the regular mattress . Neither foot had a dressing. He had multiple missing toes with black sutures extending out of the skin. The family member said the heel wounds were healing and the sutures were put in August 2024. LVN A entered the room and raised each foot. Each heel had a necrotic circular area. LVN A said the heels were supposed to be off-loaded, but the resident refused the boots to off-load them. LVN A said the sutures were dissolvable. An interview on 01/07/24 at 2:35 PM with LVN A revealed she did the wound care for Resident #1 on 01/04/25 - 01/07/25. She said she did not do the ordered wound care on his feet but signed that she did. She said that she put skin prep/betadine on the heels and left them uncovered. She said the heel wounds had been resolved. She said she did not know if the resident was supposed to have a pressure relieving mattress. LVN A said she did not know what the plan was for the sutures but was told by the ADON that they were dissolvable. She said she was not the wound care nurse. LVN A said the risk to the resident for not completing the ordered wound care and signing it as done was infection. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 01/07/24 at 3:05 PM with the ADON revealed she was also the wound care nurse. She said she looked at the wounds for Resident #1 on Monday, Wednesday, and Friday. She said she was not able to look at them on Monday because she did not work. She said the staff nurses did their own wound care. The ADON said the heel wounds were still supposed to be treated as ordered and the heel wounds were not resolved. She said the Wound Care Physician went to the facility weekly and was scheduled to arrive on 01/08/25. The ADON said she did not know if the resident was supposed to be on a pressure relieving mattress. The ADON said the facility needed to contact Resident #1's surgeon about the sutures because they had not dissolved, and she did not know why. The ADON said she did not realize Resident #1's wounds were not treated as ordered on 01/04/25-01/07/25. The ADON said the resident was at risk for a decline in his wounds if his treatments were not completed as ordered. The ADON said the Wound Care Physician did not look at surgical wounds. An interview on 01/08/25 at 1:00 PM with the DON revealed Resident #1 was going to get an air mattress. She said the staff nurses were responsible for doing the wound care and was told LVN A did not administer the ordered treatment for his heel wounds. She said she was not aware of any other residents who did not receive their ordered treatment. She said the sutures on his toes was from his surgery before he admitted to the facility. The DON said the resident still had the sutures because she was told they were dissolvable. The DON said the facility was contacting his surgeon who was out of state. The DON said the nurses were trained how to document in the electronic treatment administration record. The DON said she checked the orders every morning to ensure nurses were documenting correctly. She said if the resident did not receive the ordered wound care, he could develop infection. She said if a nurse documented a treatment was completed when it was not, then the resident was at risk for a missed treatment. The DON said she and the nurses were responsible for ensuring wound care was completed. Record review of the facility policy, Pressure Injury: Prevention, Assessment and Treatment revised 08/12/16, reflected: Procedure: 1. Nursing personnel will continually aim to maintain the skin integrity, tone, turgor, and circulation to prevent breakdown, injury and infection . 2. Early prevention and/or treatment is essential upon initial nursing assessment of the condition of the skin on admission and whenever a change in skin status occurs. .follow any orders as directed by the physician . Sign off on treatment sheet any treatment completed .

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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 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** 37028 Based on interview and record review, the facility failed to ensure that in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete and accurately documented for one (Resident #1) of three residents reviewed for nursing services. The facility failed to ensure LVN A did not falsely document that she provided physician ordered wound care for Resident #1 on 01/04/25 - 01/07/25. This failure could place residents at risk for not receiving ordered wound care. Findings included: Record Review of Resident 1's quarterly MDS assessment revealed he was an [AGE] year-old male, admitted to the facility on [DATE]. Resident's MDS revealed he had a BIMS score of 9 indicating his cognition was moderately impaired. His diagnoses included heart failure, peripheral vascular disease (a chronic condition that reduces blood flow to the arms, legs, and organs), end-stage renal disease, malnutrition, and traumatic amputation of most toes. Record Review of Resident #1's Order Summary Report, dated January 2025, reflected: 1. Cleanse wound to left heel with normal saline, pat dry, apply betadine, and cover with a gauze roll (kerlix), and secure with tape (paper) once daily and as needed for wound care. 2. Cleanse wound to right heel with normal saline, pat dry, apply collagen powder and calcium alginate, cover gauze roll (kerlix), and secure with tape (paper) once daily one time a day for wound care. 3. May have pressure relieving mattress every shift. Record review of Resident #1's electronic treatment administration record reflected LVN A documented the ordered wound care was completed on 01/04/25-01/07/25. An observation and interview on 01/07/24 at 9:50 AM with Resident #1 and his family member revealed he was lying in bed. He was awake, alert, oriented. His feet were uncovered and lying flat on the regular mattress. Neither foot had a dressing. He had multiple missing toes with black sutures extending out of the skin. The family member said the heel wounds were healing and the sutures were put in August 2024. LVN A entered the room and raised each foot. Each heel had a necrotic circular area. LVN A said the heels were supposed to be off-loaded, but the resident refused the boots to off-load them. LVN A said the sutures were dissolvable. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 01/07/24 at 2:35 PM with LVN A revealed she did the wound care for Resident #1 on 01/04/25 - 01/07/25. She said she did not do the ordered wound care on his feet but signed that she did. She said that she put skin prep/betadine on the heels and left them uncovered. She said she thought the heel wounds had been resolved. She said she was not the wound care nurse. LVN A said the resident was at risk for infection if the staff documented that wound care was completed but failed to complete it. An interview on 01/07/24 at 3:05 PM with the ADON revealed she was also the wound care nurse. She said she looked at the wounds for Resident #1 on Monday, Wednesday, and Friday. She said she was not able to look at them on Monday because she did not work. She said the staff nurses did their own wound care. The ADON said the heel wounds were still supposed to be treated as ordered and the heel wounds were not resolved. She said the Wound Care Physician went to the facility weekly and was scheduled to arrive on 01/08/25. The ADON said she did not realize Resident #1's wounds were not treated as ordered on 01/04/25-01/07/25. The ADON said the resident was at risk for a decline in his wounds if his treatments were not completed as ordered. An interview on 01/08/25 at 1:00 PM with the DON revealed staff nurses were responsible for doing the wound care and was told LVN A did not administer the ordered treatment for Resident #1's heel wounds. She said she was not aware of any other residents who did not receive their ordered treatment. The DON said the nurses were trained how to document in the electronic treatment administration record. The DON said she checked the orders every morning to ensure nurses were documenting correctly. She said if the resident did not receive the ordered wound care, he could develop infection. She said if a nurse documented a treatment was completed when it was not, then the resident was at risk for a missed treatment. The DON said she and the nurses were responsible for ensuring wound care was completed. Record review of the facility policy, Job Description Charge Nurse, dated 2014, reflected: .Timely and accurate documentation of resident's charts . Record review of the facility policy, Dressing Change Checklist, not dated, reflected: .Documents procedure per facility policy.

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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** 37028 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 one of three residents (Resident #1) observed for infection control. The facility failed to ensure the ADON wore the appropriate PPE while measuring and assessing foot wounds for Resident #1. These failures could place residents at risk of transmission of multidrug-resistant organisms. Findings included: Record Review of Resident 1's quarterly MDS assessment revealed he was an [AGE] year-old male, admitted to the facility on [DATE]. Resident's MDS revealed he had a BIMS score of 9 indicating his cognition was moderately impaired. His diagnoses included heart failure, peripheral vascular disease (a chronic condition that reduces blood flow to the arms, legs, and organs), end-stage renal disease, malnutrition, and traumatic amputation of most toes. Record Review of Resident #1's Care Plans reflected, 11/29/24 The resident had a pressure ulcer of the left heel. Facility interventions included: Document on pressure ulcer of the left heel, amt of drainage, peri-wound area, pain, edema, and circumference measurements. Evaluate wound for: size, depth, margins: peri-wound skin. Document progress in wound healing on an ongoing basis. Notify physician as indicated. There was not a care plan for the right heel. Record Review of Resident #1's Order Summary Report, dated January 2025, reflected: 1. Cleanse wound to left heel with normal saline, pat dry, apply betadine, and cover with a gauze roll (kerlix), and secure with tape (paper) once daily and as needed for wound care. 2. Cleanse wound to right heel with normal saline, pat dry, apply collagen powder and calcium alginate, cover gauze roll (kerlix), and secure with tape (paper) once daily one time a day for wound care. 3. May have pressure relieving mattress every shift. Review of Resident #1's Wound Evaluation and Management Summary reflected: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/01/25 1. Stage 4 Pressure Wound of the Right Heel: 1.5 x 0.5 x Not Measurable Centimeters with black necrotic (dead) tissue. Wound progress: Exacerbated (worsened) 2. Unstageable Wound of the Left Heel: 0.9 x 0.8 x Not Measurable Centimeters with black necrotic tissue. Wound progress: Improved 01/08/25 1. Stage 4 Pressure Wound of the Right Heel: 1 x 0.5 x Not Measurable centimeters with black necrotic tissue. Wound progress: Improved 2. Unstageable Wound of the Left Heel: 0.8 x 0.8 x Not Measurable Centimeters with black necrotic tissue. Wound progress: Improved Record review of Resident #1's electronic treatment administration record reflected LVN A documented the ordered wound care was completed on 01/04/25-01/07/25. An observation and interview on 01/07/24 at 9:50 AM with Resident #1 and his family member revealed he was lying in bed. He was awake, alert, oriented. His feet were uncovered and lying flat on the regular mattress. Neither foot had a dressing. He had multiple missing toes with black sutures extending out of the skin. LVN A entered the room, put on gloves, and raised each foot . Each heel had a necrotic circular area. LVN A said the heels were supposed to be off-loaded, but the resident refused the boots to off-load them. LVN A said the sutures were dissolvable. An observation and interview on 01/07/25 at 4:05 PM with the ADON revealed she entered Resident #1's room. The resident had a sign on his door showing that he was on enhanced barrier precautions. The ADON entered the resident's room and donned gloves. The ADON did not put on a gown. The ADON proceeded to undress each foot wound and measure/assess them. While the ADON measured/assessed the wounds on his heels, her scrubs touched the bed. The ADON said she was supposed to wear a gown and gloves for a resident on enhanced barrier precautions to prevent the spread of infection. She said she forgot to wear a gown that time. (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 on 01/08/25 at 1:00 PM with the DON revealed Resident #1 was on enhanced barrier precautions. The DON said for measuring and assessing the resident's wounds, a gown and gloves were required. The DON said failure to wear the appropriate PPE could lead to the spread of infection. Record review of the facility policy, Infection Control Plan: Overview updated March 2024, reflected: .Gowns and protective apparel 1. Gowns and protective apparel are worn to provide barrier protection and reduce the opportunity for transmission of microorganisms in the LTCF [long term care facility]. Gowns are worn to prevent contamination of clothing and to protect the skin of personnel from blood and body fluid exposures. Gowns that are selected for use in the facility will be impermeable to liquids. 2. Gowns are also worn by personnel during the care of patients infected with epidemiologically important microorganisms to reduce the opportunity for transmission of pathogens from residents or items in their environment to other residents or environments; when gowns are worn for this purpose, they are removed before the personnel leave the resident's environment . -