

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455733	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2025
NAME OF PROVIDER OR SUPPLIER  Heritage at Turner Park Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44405</b></p> <p>Based on interview and records review the facility failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Resident #1) of six residents reviewed for pain medication.</p> <p>LVN A failed to administer Resident #1 pain medicine for a complaint of pain intensity level 4 (moderate pain) out of 10 on 01/04/25; pain intensity level 4 (moderate pain) out of 10 on 01/05/25; pain intensity 5 (moderate pain) out of 10 on 01/06/25; pain intensity 5 (moderate pain) out of 10 on 01/07/25; pain intensity 7 (severe pain) out of 10 on 01/10/25, and a pain intensity 6 (moderate pain) out of 10 on 01/10/25 (intensity levels are interpreted as 0: no pain; 1 - 3: mild discomfort; 4 - 6: moderate pain; 7 - 10: Severe discomfort/pain).</p> <p>This failure placed residents at risk of not receiving timely pain management care which could result in prolonged pain and diminished quality of life.</p> <p>Findings included:</p> <p>A record review of Resident #1's incomplete Admission MDS assessment dated [DATE] revealed a [AGE] year-old female admitted on [DATE]. Resident #1 had diagnoses of Rhabdomyolysis (a condition that causes muscles to break down); Hereditary and idiopathic neuropathy (nerve damage in the peripheral nervous system (PNS) where the cause cannot be determined); and Spondylolysis, Cervical Region (a painful spine condition. It is a bony defect in the neck area [the first seven irregular bones in the spine]). The Admission MDS assessment did not reflect a BIMS summary score or that a staff assessment for mental status was conducted. Section J - Health Conditions of the Admission MDS assessment was not completed and did not indicate if Resident #1 had pain or was hurting, pain frequency, pain effect on sleep, pain interference with ADLs, or pain intensity. Section V - Care Area Assessment (CAA) Summary in the Admission MDS assessment did not trigger care areas for care planning.</p> <p>A record review of Resident #1's Care Plan Conference, dated 01/06/25, indicated focus, goals and interventions were reviewed and included discharge plan for Resident #1 to return home; Full Code; Risk for falls; UTI and antibiotics; actual wound to coccyx; and Resident #1's preferences. A baseline care plan was not available for review in the chart.</p> <p>A record review of Resident #1's order summary report printed 01/18/25 indicated:</p> <p>(continued on next page)</p>

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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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Start date 01/03/25: Tylenol Oral Tablet 325 mg. Give 2 tablets by mouth every 4 hours as needed for pain mild to moderate.</p> <p>Start date 01/03/25: Gabapentin (a drug that affects chemicals and nerves in the body that are involved in the cause of some types of pain) 100 mg Oral Capsule. Give 2 capsules by mouth three times a day for nerve pain.</p> <p>Start date 01/12/25: X-Ray Left Knee. One time only for left knee pain and swelling.</p> <p>Record review of a written statement dated 01/15/25 at 7:22 PM, RN C wrote when he worked on Sunday, 01/12/24 Resident #1's family members informed him that Resident #1 was complaining of pain to the left knee. RN C assessed the site and note it was swollen. Resident #1 rated the pain a 7 out of 10. RN C stated he administered Tylenol 325 mg, 2 tablets, called the physician, and an x-ray of the knee was ordered.</p> <p>Effective Date: 01/04/25 12:35 PM</p> <p>Type: Nursing Note</p> <p>Author: LVN A</p> <p>Note Text: Skilled Nurse Note Resident states/appears in pain. Pain rating at 4.</p> <p>Effective Date: 01/05/25 11:00 AM</p> <p>Type: Nursing Note</p> <p>Author: LVN A</p> <p>Note Text: Skilled Nurse Note Resident states/appears in pain. Pain rating at 4.</p> <p>Effective Date: 01/06/25 7:43 AM</p> <p>Type: Nursing Note</p> <p>Author: LVN A</p> <p>Note Text: Skilled Nurse Note Resident states/appears in pain. Pain rating at 5.</p> <p>Effective Date: 01/07/25 10:42 AM</p> <p>Type: Nursing Note</p> <p>Author: LVN A</p> <p>Note Text: Skilled Nurse Note Resident states/appears in pain. Pain rating at 5.</p> <p>Effective Date: 01/10/25 1:49 PM</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Note Text: Tylenol Oral Tablet 325 mg. Give 2 tablet by mouth every 4 hours as needed for pain mild to moderate pain. PRN administration was Effective. Follow-up pain scale was 0 (zero).</p> <p>Effective Date: 01/12/25 9:17 PM</p> <p>Type: Nursing Progress Note</p> <p>Author: RN C</p> <p>Note Text: [Resident #1] Complained of pain 7 out of 10 and swelling of the left knee. [Attending Physician] ordered x-ray of left knee.</p> <p>Effective Date: 01/12/25 9:30 PM</p> <p>Type: Nursing Note</p> <p>Author: RN C</p> <p>Note Text: Skilled Nurse Note Resident states/appears in pain. Pain rating at 7.</p> <p>Effective Date: 01/13/25 4:24 AM</p> <p>Type: Nursing Note</p> <p>Author: RN E</p> <p>Note Text: Skilled Nurse Note Resident states/appears in pain. Pain rating at 3.</p> <p>Effective Date: 01/13/25 8:29 AM</p> <p>Type: Nursing Progress Note</p> <p>Author: ADON</p> <p>Note Text: X-ray tech present at facility to do left knee x-ray will await results.</p> <p>Review of Resident #1's January 2025 MAR reflected RN E administered Tylenol 325 mg, 2 tablets, on 01/12/25 at 12:56 AM for an unknown level of pain. RN C administered Tylenol 325 mg, 2 tablets on 01/12/25 at 7:23 PM for a pain level of 7 (severe) out of 10 to the left knee and swelling. There were no other entries on the MAR that indicated Tylenol was administered from 01/03/25 through 01/11/25.</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/18/25 at 12:11 PM, LVN A said that she worked 6A - 2P shifts. LVN A said when she was scheduled, or picked up extra shifts, she was assigned as Resident #1's nurse. LVN A said that Resident #1 was a new admission and resided at the facility for less than 3 weeks. LVN A said that Resident #1 was alert and oriented to self, surroundings, was occasionally confused and needed prompts or cues about the date or time of day. LVN A said that Resident #1 could voice and make her wants and needs known. LVN A said Resident #1 required 2-persons to assist with toileting and transferring. LVN A said that Resident #1 was wheelchair bound and required the mechanical lift for transfers. LVN A said that Resident #1 never complained about pain or requested pain medication.</p> <p>During a phone interview on 01/19/25 at 4:26 PM, RN E said that she worked 10P - 6A shifts. RN E said that when she was scheduled, she was assigned as Resident #1's nurse. RN E said that Resident #1 did not often complain about pain. RN E said when she worked on 01/11/25, Resident #1 said that she was hurting behind her knees. RN E said that she did not recall the pain level before she administered the Tylenol. RN E said that Resident #1's knee(s) were not swollen when asked if she checked and noticed any swelling, redness, or felt any warmth behind Resident #1's knees at the time she complained of pain. RN E said when she followed up with Resident #1 around 1:30 AM (01/12/25), the Tylenol was effective because [Resident #1] said she was okay.</p> <p>During a phone interview on 01/19/25 at 4:53 PM, LVN A stated that Resident #1 received a routine pain medication, and she would assess Resident #1's pain level prior to administering routine medications. LVN A identified the routine pain medication as Gabapentin that was given for nerve pain. LVN A said that Resident #1 would indicate her pain was generalized. LVN A said that she did not administer PRN Tylenol to Resident #1 because the Gabapentin relieved any pain Resident #1 had. LVN A acknowledged that there were medication aides who administered routine medications to Resident #1 and stated that LVN A administered medications on the weekend. LVN A could not speak to why she stated she administered routine medications to Resident #1 during the weekday or to why she did not assess the severity and the impacts of the pain on Resident #1. LVN A denied performing or suggesting coping strategies or non-pharmacological pain management techniques to assist Resident #1 with pain relief.</p> <p>Review of the facility's policy Pain Management, Assessment Scale revised May 25, 2016, indicated complaints of pain will be assessed accordingly by the nurse and effectively managed through prescribed medications, comfort measures, and all available resources of the facility.</p> <p>Procedure</p> <ol style="list-style-type: none"> <li>1. Assess resident's physical symptoms of pain, physical complaints, and daily activities.</li> <li>2. Perform comfort measures to promote relaxation.</li> <li>5. Apply heat or cold as ordered to minimize or relieve pain.</li> <li>6. Help resident into a comfortable position and use pillows to splint or support painful areas, as appropriate, to reduce muscle tension or spasm and to redistribute pressure on body part.</li> <li>7. Ask resident to help establish goals and develop plan for pain control.</li> <li>8. Instruct resident in use of relaxation techniques.</li> </ol> <p>(continued on next page)</p>		

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