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	06/06/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observation, interview, and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 8 residents (Resident #30) reviewed for abuse. The facility failed to ensure LVN A did not verbally abuse Resident #30 on 6/4/24 during lunch service when LVN A had a witnessed, verbal altercation with Resident #30. The altercation occurred in the presence of other residents. This failure could place residents at risk of abuse, humiliation, intimidation, fear, shame, agitation, and decreased quality of life. Findings included: Record review of Resident #30's Admission Record revealed he was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Record review of Resident #30's Quarterly MDS assessment dated [DATE] reflected he had moderately impaired cognition, used a wheelchair for mobility and required partial to moderate assistance with eating. The MDS Assessment reflected his diagnoses included: hypertension (high blood pressure), non-Alzheimer's dementia (changes in the brain that can cause forgetfulness, limited social skills, impaired thinking, irritability, and extreme mood swings). Record review of Resident #30's Care Plan reflected the following entries: An entry dated 3/10/22 and revised on 2/23/24 reflected: Focus: [Resident #30] has impaired cognitive function and impaired thought processes r/t Neurological symptoms, Short and Long term memory loss . Interventions: . Ask yes/no questions in order to determine the resident's needs . Cue, reorient and supervise as needed . Use task segmentation to support short term memory deficits. Break tasks into one step at a time. An entry dated 3/10/22 and revised on 2/23/24 reflected: Focus: I have an ADL self-care performance deficit r/t CVA .Interventions: . EATING: I am able to feed self with set-up assistance . Encourage me to participate to the fullest extent possible with each interaction . When assisting, observe for any changes in my ability to participate in my care and report any changes in ADL function . (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/4/24 at 1:22 AM, Resident #30 was observed in his room, sitting in a wheelchair. He was well-dressed and groomed and was holding a toothbrush and toothpaste. He denied any concerns or complaints about his care at the facility. During an observation in the dining room on 6/4/24 at 12:31 PM, Resident #30 was observed sitting at a table by himself eating lunch. There were approximately six residents still eating their lunch. LVN A was observed several feet away from Resident #30 at another tab le attending to other residents. Resident #30 called out to LVN A stating he wanted a coffee refill. (This Surveyor G was standing at a table situated between Resident #30 and LVN A talking to Residents #14 and #56). LVN A stated, He normally gets it himself;, he's being lazy today. LVN A was speaking loudly enough to be heard by Resident #30. Resident #30 stated, She's being mean to me! LVN A stated, That's what he does when he doesn't want to get it himself. Resident #30 appeared angry and yelled out, I'm reporting you to the State! LVN A replied loudly, I'm reporting myself to the State right now! This Surveyor G approached Resident #30 and asked him whether he typically refilled his own coffee and he replied, no. He motioned toward the coffee container which was situated on a bar across the room and stated he did not like to because it was a little high for him. LVN A, still standing a few tables away, stated, Oh you big liar, he can do it himself. The DON entered the dining area and was waved down by Resident #30. Resident #30 asked him to get him some more coffee. The DON took his cup, refilled his coffee, retrieved extra sugar for him then left the dining area. It was unclear whether the DON had heard any of the verbal exchange. After the DON left the area, LVN A stated, you can do it, I've seen you do it, you tell stories to everyone. I'll remember that tomorrow. Resident #30 turned his attention to drinking his coffee and appeared to ignore LVN A's remark. LVN A continue to assist other residents and pick up tray. ADON B entered the dining room and also began to remove trays. Resident #30 left the dining room with no further verbal exchange. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/24 at 12:59 PM, LVN A was asked what she meant when she said to Resident #30 'I'll remember that tomorrow'. She stated, I said that because he'll get his own coffee tomorrow, like there are times he'll have other residents push him to his room, I've had to ask him to stop doing that before another resident gets hurt. This is his behavior. He gets his own coffee himself all the time, but when a manager or someone walks in, he acts like that. When asked if she felt it was appropriate to call him a liar across the dining room, LVN A denied saying it. When this Surveyor G read her quote to her, LVN A stated she only did it once because he does that all the time, he comes in the dining room and demands, 'where's my food?', I'll tell him to come and sit and be patient and he'll get angry. When asked if she routinely cared for Resident #30 and if his behaviors had ben care planned, LVN A stated he did not reside on her hall, and she mainly interacted with him in the dining room or the hallway. She stated she would normally interact with him and joke around in the hallway but in the dining room he acts like 'Bring it to me!' He demands it immediately only when someone else walked in. LVN A stated she had received training on Abuse and Neglect the day before. She stated she did not consider the incident to be verbal abuse because, Technically he was lying because he said he never does it and he does it all the time, when someone's around, he acts like that. When asked if she felt it was appropriate to treat someone like that who had those types of behaviors, LVN A stated, no and stated she normally did not react when he did it. She stated she would normally say, go get your coffee and he would go, but then he would start complaining. She stated he would cut her off whenever she tried to talk to him just as he would when she would ask him not to have residents push his chair. She stated she would ask him to stop, and he would start yelling if she said something he did not want to hear. She stated she knew there was a risk of escalating Resident 30's behavior but sometimes he got under her skin, and she knew she should not let him get to her. LVN A stated the risk of altercations with other residents present was that it could escalate other resident's behaviors. She stated, All we're trying to do is to get him to do more for himself when he doesn't want to. She stated her comment of I'll remember this tomorrow meant he's going to start with 'get me my coffee or I'll get the State'. She stated the comment was not a threat to the resident. During an interview on 6/4/24 at 1:16 PM with the Administrator, DON and Area Director of Operations, the Administrator stated he had been made aware by LVN A that she had a disagreement with Resident #30 and had been removed from the floor. The Administrator stated he was familiar with Resident #30, and he would stop him in the dining room and ask for coffee. He stated Resident #30 would ask him for additional refills before finishing his current one. The DON stated he began working at the facility the previous week and was often in the dining room. He stated Resident #30 would cross the dining room to get his attention or that of another staff member. This Surveyor G reported the events witnessed in the dining room during lunch observations. The Administrator stated verbal altercations and arguing with residents could cause psychological issues for the resident. The DON stated altercations could lead other residents' behaviors and be perceived as aggression. The Administrator stated LVN A would be suspended pending an investigation and a report would be called into the State. He stated the ADONs and DON would assess Resident #30. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 6/4/24 at 2:28 PM, Resident #30 was observed being wheeled into his room by facility staff who told him they would be right back to assist him. Resident #30 stated he was doing fine. Resident #30 stated LVN A was the only staff member who made him angry. He denied ever complaining about her in the past. He stated he did get his own coffee at times but did not want to that day because he was afraid that he would spill it. He stated he saw LVN A getting coffee for other people all the time and she made him angry that day at lunch. He stated he believed LVN A had an attitude. He denied any other complaints and stated he was glad the situation had been reported. An observation and interview on 6/4/24 at 2:57 PM revealed Resident #56 and Resident #14 were sitting in their room. Both residents stated they were not bothered by the altercation in the dining room between Resident #30 and LVN A and neither could recall ever seeing any staff being rude to residents. Resident #56 stated he had previously seen Resident #30 be rude to LVN A. During an interview on 6/5/24 at 8:19 AM, CNA D stated she worked on Resident #30's hall. She stated she had not seen Resident #30 ever pour his own coffee but did not often work in the dining room during meals. She stated he would ask her to get coffee for him at times. CNA D stated Resident #30 was usually friendly but, depending on his mood, would occasionally yell or speak abruptly at staff. She stated she had never seen him have any altercations or complaints with staff members. During an interview on 6/5/24 at 8:38 AM, Resident #39 stated he had been in the dining room during lunch on 6/4/24. When asked if he had noticed any altercations there, he replied, They guy with the coffee? Yeah. He stated he had never noticed, and staff get into altercations or be rude with anyone before and was not bothered by it. He stated Resident #30 just gets mad sometimes. An observation and interview on 6/5/24 at 9:07 AM revealed Resident #30 was self-propelling in the hallway in his wheelchair, smiled and said hello. Resident #30 asked this Surveyor G if I was there yesterday and he was reminded I had spoken with him in his room and dining room. Resident #30 laughed and stated, Oh yeah!. He stated he was doing just fine today. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/24 at 9:21 AM, ADON C stated she had been working at the facility for about 2 months. She described Resident #30 as very polite to her, alert and oriented, could definitely make his needs known. She stated he knew what he wanted and liked such as not wanting to get up early in the morning, he would definitely let the nurse know about it. She stated she did not recall seeing him in any altercations with staff. She stated it was in his nature to say something like, hey move! if someone was in his way but nothing volatile. ADON C stated she had seen him in the dining room in passing and he would sit at his own table and feed himself. She stated she had seen him go and retrieve his own coffee and did not recall him having any difficulty with it. ADON C stated she had previously seen him interact with LVN A and it was usually laughing and joking, never bickering, or having cross words. ADON C stated she did not believe his behaviors warranted any special care plans other than the general behavior monitoring for changes that would go along with medications or cognitive issues. She stated he was generally a laid-back guy. ADON C stated she spoke with Resident #30 in the afternoon on 6/4/24 and he told her he was upset about the altercation. She stated he made some small-talk afterward and told her he was doing okay. She stated he had never mentioned anything like it happening before. ADON C stated the facility had just completed in-servicing related to abuse, neglect, and misappropriation the week before. She stated, had she witnessed the situation, she would have asked LVN A to leave, assisted the resident with his needs and report the situation to the Administrator immediately. ADON C stated they had ongoing conversations with the staff regarding burnout and they were always encouraged to ask for help, step away for some air, and ask managers for help if they felt themselves getting upset. She stated the risk of verbal abuse or altercations with residents was escalation of behaviors. An observation on 6/5/24 at 12:38 PM revealed Resident #30 was sitting in the dining room eating lunch. When asked how he was doing, he lifted his coffee cup, smiled and replied, good. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/24 at 12:48 PM, ADON B stated she conducted in-service training in the facility and had just conducted training related to Abuse and Neglect on 5/30/24. She stated the in-service included a review of verbal, physical and mental abuse, as well as misappropriation. She stated examples of each type were discussed and the importance of calling the administrator immediately for any suspected occurrences. When asked what was meant by 'mental abuse', ADON B described it as generally messing with them and gave the example of, if you know a resident hates red and you're constantly showing them red things, doing things that could trigger them or cause them to become upset. She described verbal abuse as degrading a resident like calling them by a name when you know they asked to be called by another. She stated calling a resident a 'liar' would be considered verbal abuse because you were attacking their character. ADON B stated she had not heard anything when she entered the dining room during lunch on 6/4/24 and was coming to assist the residents who were finishing their meals. ADON B stated she was occasionally asked by Resident #30 for coffee when she rounded through the dining room during breakfast, and she did not recall ever seeing him pour his own. She stated he would yell out at her in the hallway at times just to say hello. ADON B stated she did not recall Resident #30 ever getting into altercations with staff or other residents. She stated, when Resident #30 wanted something, it was part of his demeanor to say I want it now but she did not feel that warranted a special care plan. She stated they just got him what he needed, and he was fine. The Corporate Compliance Nurse joined the interview and stated managers were trained about staff burnout and the importance of paying attention to the staff for indications of burnout. She stated staff were constantly reminded to reach out to managers if they were feeling overwhelmed and needed a break. ADON B stated she was constantly on the floor checking to see if the staff needed any assistance and they all knew to call her in the evening and on weekends as well. The Corporate Compliance Nurse stated the facility also provided additional ongoing computer-based training to staff that touched on burnout, abuse, and other topics. She stated the courses were a requirement and she would pull a transcript for LVN A showing the trainings she had completed. ADON B stated her expectation was that if a resident requested a cup of coffee, regardless of their behaviors, they should be provided with it as just good customer service. She stated if a staff member felt a resident was getting 'under their skin', they should step away to cool off or report to their manager for assistance. She stated the risks of verbal or mental abuse included psychological harm, fear, depression, and escalation of behaviors. She stated the risks to residents witnessing staff to resident altercations included fear of staff and increased behaviors themselves. During an interview on 6/5/24 at 1:20 PM, LVN E stated she regularly cared for Resident #30. She stated he was receiving medications for anxiety and sometimes had periods of confusion making it difficult to tell if he was joking or not. She stated he sometimes had verbal exchanges with other residents, including his roommate, but it was never more than just bickering. LVN E stated she had previously never heard of him having any altercations with staff members. She stated she had not observed him in the dining because she usually worked the 2 PM to 10 PM shift and was assigned to another dining room at dinner. LVN E stated she was made aware had had been in an altercation and was told to monitor him for any changes. She stated she had not noted anything out of the ordinary for him. She stated the risk to residents involved in altercations with staff was it was demeaning to the resident;, they may feel less important and have a decrease in dignity. She stated the risk to residents witnessing staff to resident altercations was they might be taken aback and feel uncomfortable around staff. An observation and interview on 6/6/24 at 12:55 PM revealed Resident #30 was sitting in his room watching television. He stated things were going well and had improved in the dining room. He expressed his appreciation that people had listened to him and denied any concerns. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 6/6/24 at 12:58 PM, LVN F stated he was working the day shift on 6/4/24 and taking care of Resident #30. He stated he had been informed the resident had been in an altercation and monitored him for any distress. LVN F stated he checked on Resident #30 and he did not show any concerns or distress. He stated the resident had a visit from a family member and they left the unit to visit. LVN F stated he had never seen Resident #30have any altercations with staff. He stated he could definitely demand what he wanted. He stated if was never acceptable to argue with him, just smile and get it, that's his personality. LVN F stated he was usually assigned to a different dining room during meals so he rarely saw Resident #30 in the dining room but, when he did, the resident would occasionally stop him and ask for things like extra sugar. LVN F described verbal abuse as as cussing at residents, exchanging words or being argumentative with residents. He stated the risk to residents included mental distress and depression. He stated the risk to resident bystanders during a staff to resident altercation included fear of the situation and fear of asking the staff for assistance because they may be abused. In an interview on 6/6/24 at 1:20 PM, ADON C stated they were still monitoring Resident #30 for any adverse effects. She stated a psychiatric nurse had met with Resident #30 on 6/4/24 and had no immediate concerns. During an interview on 6/6/24 at 1:36 PM, the DON stated LVN A continued to be suspended. He stated they had initiated in-service training for all staff related to abuse, resident rights, interacting with residents and customer service. The DON stated they had a psychological consultation completed for Resident #30 on 6/4/24. He stated he continues to check on Resident #30 and staff monitored him every shift and in the dining room. He stated he felt the risk for residents was they may become fearful to ask for help. During an interview with the Administrator on 6/6/24 at 1:49 PM, he stated he had been investigating the incident and LVN A would not be returning to the facility. He stated their investigation determines she had been properly trained and she still acted the way she acted. The Administrator stated the DON and ADONs continued to follow-up with Resident #30 and he had spoken with him as well. He stated safe surveys were conducted with residents and no other complaints had been reported. The Administrator stated he expected the staff to reach out to management if they felt stressed, take a break or walk away. He stated verbal abuse placed residents at risk for suffering anxiety and make them fearful of asking for help. During an interview on 6/6/24 at 2:12 PM, the Social Worker described verbal abuse as screaming at a resident, calling them by different names, or being verbally demeaning. She stated she had not received any complaints from residents or family members regarding abuse and had never received any complaints regarding LVN A. The Social Worker stated she had conducted safe surveys with facility residents as part of the abuse investigation and had not received any complaints or concerns from the residents. The Social Worker stated the risks to residents involved in verbal altercations with staff included they could become fearful of retaliation, experience an escalation in behaviors and sustain psychosocial harm. She stated the risk for other residents who may witness staff to resident altercations was that may become fearful and think, that can happen to me. Record review of the facility's in-service dated 5/30/24 conducted by ADON B reflected the staff were trained on the facility's Abuse/Neglect policy and procedure. The In Service Training Attendance Roster reflect the training had been attended by LVN A. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy and procedure titled, Abuse/Neglect dated Revised 3/29/18 reflected the following: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart . Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. Definitions: 1. Abuse: Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .3. Verbal Abuse: Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents, or within their hearing distance, regardless of their age, ability to comprehend, or disability .Procedure: A. The facility will conduct criminal background checks of all personnel in accordance with Texas Health and Safety Code, Chapter 250 .C. Prevention: The facility will provide the residents, families, and staff an environment free from abuse and neglect .

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47030 Based on interview and record review, the facility failed to transmit resident assessments within the required time frame for 3 of 3 discharged residents (Resident #1, #3, #59) reviewed for data encoding and transmission to CMS that: The facility failed to ensure the resident's assessments were encoded and transmitted timely. Resident #1 ARD was due on 5/3/2024 according to the resident's individual ARD- Assessment Reference Date. Resident #3 ARD was due on 5/3/2024 according to the resident's individual ARD- Assessment Reference Date. Resident #59 ARD was due on 5/2/2024 according to the resident's individual ARD- Assessment Reference Date. This failure placed residents at risk for not having their MDS Assessments transmitted in a timely manner. The findings included: Record review of Resident #1's face sheet revealed the resident original admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1's admitting diagnoses included Metabolic Encephalopathy- (Degeneration of brain function), contracture- (a shortening or distortion of muscular or connective tissue) of right knee, contracture of left knee, chronic diastolic (congestive) heart failure. Record review of Resident #1's EMR revealed the resident's last quarterly MDS dated [DATE] MDS with ARD date of 05/03/2024 was not encoded and transmitted as of 06/10/2024. Record review of Resident #3's face sheet revealed the resident original admitted to the facility on [DATE] and readmitted on [DATE]. Resident #3's admitting diagnoses included essential hypertension, anxiety disorder, glaucoma with increased episcleral venous pressure. Record review of Resident #3's EMR revealed the resident's last quarterly MDS dated [DATE]. MDS next ARD date of 05/03/2024 was not encoded and transmitted as of 06/10/2024. Record review of Resident #59's face sheet revealed the resident admitted to the facility on [DATE]. Resident #59's admitting diagnosis included unspecified dementia, unspecified severity, without disturbance, psychotic disturbance, mood disturbance and anxiety. Record review of Resident #59's EMR revealed the resident's last quarterly MDS dated [DATE]. MDS next ARD date of 05/02/2024 was not encoded and transmitted as of 06/10/2024. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/06/24 at 02:42 PM with MDS coordinator indicated she as the only MDS coordinator at this time and she took over the position about a month ago. The MDS coordinator revealed there are some MDS that have been completed but not sent CMS. The MDS coordinator revealed she follows the facilities MDS Policy for the scheduling of assessments. The MDS coordinator revealed the corporate office sends staff to the facility to assist and sign the MDS for transmittal. The MDS coordinator revealed the importance was to provide a picture of the care for the resident. The MDS coordinator stated the new Director of Nursing was not, yet MDS trained. Interview on 06/06/2024 at 3:00pm with the administrator revealed understanding of the importance of transmitting the MDS assessments in a timely manner. The facility's policy for MDS assessment data accuracy 2.2021 revealed Purpose/Policy 7. The OBRA schedule and if applicable the Medicare PPS assessment schedule must be followed for setting of the Assessment Reference Date (ARD) and completion of the MDS assessment. Please refer to CMS's RAI 3.0 Version Manual for the scheduling of assessments. CMS's RAI-Resident Assessment Instrument Version 3.0 Manual. Chapter 5: Submission and Correction of the MDS Assessments 5.2 Timeliness Criteria In accordance with the requirements at 42 CFR S483.20(f)(1), (f)(2), and (f)(3), long-term care facilities participating in the Medicare and Medicaid programs must meet the following conditions: o Encoding Data: Within 7 days after completing a resident's MDS assessment or tracking record, the provider must encode the MDS data (i.e., enter the information into the facility MDS software). The encoding requirements are as follows: - For a Quarterly, Significant Correction to Prior Quarterly, Discharge, or PPS assessment, encoding must occur within 7 days after the MDS Completion Date (Z0500B + 7 days).