STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455748	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Hall	2021 Shoaf Dr Irving, TX 75061

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 - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	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** 47794 Based on interview and record review, the facility failed to ensure residents 1 of 14 residents (Resident #1) were free from neglect. The facility failed to provide adequate wound care monitored by a physician for 30 days for Resident #1 with a Stage IV pressure sacral ulcer, skin tear of right knee, and pressure ulcer of left foot. The resident was sent to the hospital by the facility after with symptoms of lethargy, disoriented, anorexia and hypotensive. Resident was admitted to the hospital ICU as septic, had fluid overload with shortness of breath. The facility neglected Resident #1 daily wound care treatment and wound care management by physician services. These failures could place residents at risk for neglect due to facility not providing needed care and services. An Immediate Jeopardy (IJ) was identified on 3/20/2024. The ED was notified and provided with the IJ template on 3/20/2024 at 5:36 PM. While the Immediate Jeopardy was removed on 3/22/2024, the facility remained out of compliance at a scope of pattern and a severity level of actual harm with the potential for more than minimal harm, due to the facility's need to implement and monitor the effectiveness of its corrective systems. Findings included: Record review of resident's electronic medical record history and physical revealed Resident #1 is an [AGE] year-old, female with a history of hypertension, pressure ulcer of sacral region, chronic respiratory failure with hypoxia (Chronic Obstructive Pulmonary Disease), dysphagia (difficulty swallowing), and end stage renal disease (kidney failure/dialysis required for blood filtration). Record review of resident's Nurse 24-hour Report identified two small skin tears on sacrum on 1/4/2024. (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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of resident's Care Plan on dated 5/5/2023 states Resident #1 is at risk for skin breakdown/pressure ulcer/injury. Record review of Specialty Physician Wound Evaluation and Management Summary revealed Stage 3 sacrum pressure wound (resolved on 7/28/2023) for Resident #1. Electronically signed by Physician A on 7/28/2023. Record review of resident's Nurse 24-hour Report identified two small skin tears on sacrum on 1/4/2024. Record review of resident's wound management notes document a sacral pressure ulcer for 5/11/2023, 6/1/2023, and 2/1/2024. This revealed a lapse weekly documented skin checks for Resident #1 from 2/7/2024 to 3/4/2024. Record review of Nursing Administration History: 2/7/2024 to 3/4/2024 physicians orders for wound care administration for sacrum: (Cleanse with NS or wound cleanser, pat dry, apply alginate calcium and cover with dry dressing daily.) Notes documented by LVN A and RN E from 2/10/2024 to 3/2/2024 Not Administered: To be done by wound nurse. Record review of LVN A progress note dated 3/4/2024 stated wound size is 1.7 x 1.2 cm, edges black in color. In an interview with the facility ADON B on 3/19/2024 at 1:20 PM stated she was hired on 2/15/2024 and Resident #1 transitioned to my roster the same day I discharged her to the hospital due to her nurse notifying me of her change in condition on 3/5/2024. Her assigned nurse said her wound dressing was soiled and she changed it before EMS arrived on 3/5/2024. The investigator asked, where are the Bath sheets? Because I did not see them documented in the EMR skin assessments. ADON stated, Look on my watch this will change. That is a problem we have been working on. We have started in-services at the beginning of March with CNAs documenting skin assessments during ADL care. Yes, we are really working on improving documentation and making sure CNAs documenting what they see. In a phone interview with the facility contracted wound care Physician A on 3/19/2024 at 1:30 PM he stated he approved the telephone orders for Resident #1's sacral pressure wound requested by ADON C on 2/7/2024 . Physician A stated, I go to the facility every Thursday. I don't recall seeing that patient because I don't have any notes or any evidence of her making it to the rounding list. Not sure why if it was forgotten or if she was out of the building. For some reason she never made it. I just approved the order through a call. I don't know why she was never on the list. When I go into the building, they give me a list of everyone, and I make sure I see everyone. If someone was supposed to be there that's not there, there's no way for me to just, out of the top of my mind, troubleshoot. Who is this person? Unless it's someone I've seen the week before, I would ask them did this person go home? Why are we not seeing this person, for whatever reason. She had told me that patient was supposed to be seen, but somehow, she was not on the list. The resident was never on the list. I'm not sure why. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	In a phone interview with the Responsible Party (RP) on 3/19/2024 at 4:30 PM she stated, Resident #1 would call me in the middle of the night in excruciating pain. She told the nurses continually that she was an excruciating pain. One would think the nurses communicated that to somebody so somebody would have taken care of this prior to her suffering for a month in excruciating pain. I don't understand how it went on that long. In a phone interview with Resident #1's facility Primary Care Physician B on 3/20/2024 at 10:19 AM he stated he was not aware of any of Resident #1's wounds. In an interview with the facility ADON B on 3/20/2024 at 12:10 PM she stated, After researching the issues in documentation in skin assessments and other areas, we are still in-servicing CNA's and those giving ADL care we educated them on using the skin note and the POC to identify issues, also to verbally communicate to the nurses. For nurses we initiated the Events feature in the EMR template to be sure and educated them how use this feature when they identify problem. Nurses open the event fill it out and leave it open so we (DON/ADON's/ED) can follow up and complete it and investigate to see you know what needs to be done. Nurses were educated that if they find a skin concern, they have to notify the doctor get an order notify the family, their doctor and ED. The investigator asked, what is your expectation when a resident has not been seen by the wound care doctor? We instructed them to speak up and they should be involving their primary care doctor here in the facility as well in case something happens, or you know if something doesn't get sent or doesn't get caught. You know both providers need to be involved in the care, so nothing is overlooked. Even if their primary care provider is not in the facility. If a resident has a wound, nurses need to say they have a resident with a wound and need a referral consult to a wound care provider. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	In an interview and EMR template review with the facility ED on 3/21/2024 at 2:18 PM she stated, I identified back on January 31, 2024 that we needed to set up a protocol with the nurses to do weekly skin assessments for residents due on Mondays during the 6:00 AM to 2:00 PM shift. So, when a nurse goes into their dashboard, they can see what skilled nursing is due in a residents' chart in the EMR platform. Nurses would add a skin assessment which was called the weekly body observation. Unfortunately, it was not setup in a way, so the nurse managers (DON and ADONs) were responsible for auditing for these skin assessments, to make sure the assessments were done. That audit feature has been corrected for the ADON's and will be ready for the new DON when she starts in February. In fact, we discovered skin assessments still weren't getting done because it came up in a compliance audit after you (Investigator) entered the facility for this investigation. So, we began in-servicing the nurses on skill charting and documenting skin assessments in their progress notes. Now we have created a template in the EMR platform that uses checkmarks, to describe the nurses' findings during skin assessments and it turns into progress note. Now when I log into the EMR and see my scheduled compliance reports; I can pull these skilled tasks dated from 3/20/2024 and on. Moving forward, I will address any incomplete tasks in the morning meetings. I now, can see exactly what is going on the clinical side. I have set a lot of our skilled scheduled assessments, referrals, and other tasks to alert me so I can see exactly what was not done and from there I can follow up the nurse managers and the nurse responsible. I can no longer solely depend on the DON and ADON's to monitor assessment audits. I want to monitor it too. I can look at referrals and see if everything has been done so that will the event will trigger the consult or put in order. I have access to all now, so I can just go in and see if referrals have been done or rather if a consult or referral has not been done. Referral consults must be submitted through the wound care physician consultants' website. That's a manual process. Eventually, we want to get where our EMR system does feed referrals to their system. Now in my dashboard I can look at the order and see what was done and not done daily. As soon as identify a referral was not made, I'm immediately on the phone with the consultants, saying you have wound care consult in house. This was determined to be an Immediate Jeopardy (IJ) on 3/20/2024 at 11:45 AM. The ED and ADONs were notified. The ED was provided with the IJ template on 3/20/2024 at 5:36 PM. The following Plan of Removal (POR) submitted by the facility was accepted on 3/21/2024 at 1:48 PM: Plan of Removal On 3/14/2024 ADON's completed an in-service for Change of Condition using our SBAR should be c ompleted on any change of condition. Progress Notes should be completed every shift for the next 3 days following SBAR. 3/20/2024 3/18/2024 Administrator started reviewing resident 1 records, in-services were started to include Abuse, Neglect and Reporting. On 3/19/2024 at 5:00pm ADON's started a skin sweep of all residents, any negative findings were corrected by orders added and referrals were made to Wound Physician. On 3/19/2024 4:40pm ADON's started an in-service with all Licensed Nurses, Med aides and C.N.A's regarding skin/wound documentation and notification in their documentation in the POC. 3/20/2024 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	On 3/20/2024 at 9:00am ADON assisted Administrator in reviewing the events our system has available. On 3/20/2024 the new form for Pressure Sore/Stasis Ulcer was updated in the system and added to the events for the nurses to start using. In-service was started with all Licensed Nurses to complete the event when a Pressure Sore/Stasis Ulcer is present. The Braden Scale for Predicting Pressure Sore risk will be completed X4 Weeks after admissions or re-admissions. Quarterly thereafter. 3/20/2024 The Administrator/DON will pull the Event reports daily to ensure all orders are in place and referral completed for Wound Physician to see on their next rounds. Administrator/DON will follow up after each round conducted by the physician to ensure resident was seen and orders carried out. Any negative finding will be corrected immediately. 3/20/2024 All Licensed Nurses will be checked off for wound care for ADON's. DON/ADON's will complete observation wound care weekly for each nurse to ensure they are completing it correctly. 3/21/2024 On 3/14/2024 ADON's completed an in-service for Change of Condition using our SBAR should be completed on any change of condition. Progress Notes should be completed every shift for the next 3 days following SBAR. 3/20/2024 3/18/2024 Administrator started reviewing resident 1 records, in-services were started to include Abuse, Neglect and Reporting. On 3/19/2024 at 5:00pm ADON's started a skin sweep of all residents, any negative findings were corrected by orders added and referrals were made to Wound Physician. On 3/19/2024 4:40pm ADON's started an in-service with all nursing staff regarding skin/wound documentation and notification in include documentation in POC. 3/20/2024 On 3/20/2024 at 9:00am ADON assisted Administrator in reviewing the events our system has available. On 3/20/2024 the new form for Pressure Sore/Stasis Ulcer was updated in the system and added to the events for the nurses to start using. In-service was started with all Licensed Nurses to complete the event when a Pressure Sore/Stasis Ulcer is present. The Braden Scale for Predicting Pressure Sore risk will be completed X 4 Weeks after admissions or re-admissions. Quarterly thereafter. 3/20/2024 On 3/20/2024 at 9:00am ADON assisted Administrator in reviewing the events our system has available. On 3/20/2024 the new form for Pressure Sore/Stasis Ulcer was updated in the system and added to the events for the nurses to start using. In-service was started with all Licensed Nurses to complete the event when a Pressure Sore/Stasis Ulcer is present. The Braden Scale for Predicting Pressure Sore risk will be completed X 4 Weeks after admissions or re-admissions. Quarterly thereafter. 3/20/2024 All Licensed Nurses will be checked off for wound care for ADON's. DON/ADON's will complete observation wound care weekly for each nurse to ensure they are completing it correctly. 3/21/2024 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of facility Change in a Resident's Condition or Status Policy Statement (Revised 2021): Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, ., resident rights, etc.). 2. A significant change of condition is a major decline or improvement in the resident's status that: c. requires interdisciplinary review and/or revision to the care plan. Record review of facility Resident Rights Policy Statement (Revised 2016): Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation; 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: f. communication with and access to people and services, both inside and outside the facility. Record review of facility policy (Revised 2017): Abuse, Neglect, and Reporting: Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Policy Interpretation and Implementation - Role of the Administrator: 5. The administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. Reporting 2. An alleged violation of abuse, neglect, .will be reported immediately, but not later than: a. two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury. Monitoring of POR Record review of the facility's In-service dated 3/14/2024 completed by facility ADON's for Change of Condition using Situation, Background, Assessment, and Recommendation (SBAR). Record review of the facility's In-Service dated 3/19/2024 completed by ADON's regarding skin/wound documentation and notification in their documentation in the Point of Contact (POC). Record review of Plan of Correction (internal for facility) provided by ED The Administrator/DON will pull the Event reports daily to ensure all orders are in place and referral completed for Wound Physician to see on their next rounds. Administrator/DON will follow up after each round conducted by the physician to ensure resident was seen and orders carried out. Any negative finding will be corrected immediately. ADON assisted Administrator in reviewing the events our system has available. On 3/20/2024 the new form for Pressure Sore/Stasis Ulcer was updated in the system and added to the events for the nurses to start using. In-service was started with all Licensed Nurses to complete the event when a Pressure Sore/Stasis Ulcer is present. The Braden Scale for Predicting Pressure Sore risk will be completed X 4 Weeks after admissions or re-admissions. Quarterly thereafter. All Licensed Nurses will be checked off for wound care for ADON's. DON/ADON's will complete observation wound care weekly for each nurse to ensure they are completing it correctly. (signed by the ED) Record review of the facility's Change in Condition Policy (copied for evidence) - No concerns noted. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Interviews were conducted on 3/21/2024 at various times to include staff from various shifts. Interviews with ED, CNA A, CNA B, CMA A, LVN B, RN A, RN B, RN C, RN D, ADON A, ADON B to verify the in-services were conducted and to validate the staffs understanding of the trainings for Abuse, Neglect , and Exploitation, the importance skin/wound documentation and notification in their documentation in the Point of Contact. No concerns were found regarding the understanding of the requirements, training materials or expectations. All interviewed staff were able to communicate their understanding and proficiency of the in-services. On 3/22/2024 at 12:50 PM Investigator notified ED the immediacy was removed and conducted the exit. Immediate Jeopardy (IJ) was identified on 3/20/2024. While the IJ was removed on 3/22/2024, the facility remained out of compliance at a lowered severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy and a scope of pattern as the facility continued to monitor the implementation and effectiveness of their plan of removal.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47794 Based on interview and record review, the facility failed to ensure residents received treatment and care according to professional standards of care and the care plan to prevent pressure ulcers or develop new ulcers for 1 of 14 residents (Resident #1) reviewed for pressure ulcers. The facility failed to provide adequate wound care monitored by a physician for 30 days for Resident #1 with a Stage IV pressure sacral ulcer, skin tear of right knee, and pressure ulcer of left foot. The resident was sent to the hospital by the facility after with symptoms of lethargy, disoriented, anorexia and hypotensive. Resident was admitted to the hospital ICU as septic, had fluid overload with shortness of breath. The facility failed to add the resident to wound care physicians list of patients for pressure ulcers. These failures could place residents at risk of development of additional pressure ulcers and further health decline. Findings included: Record review of resident's electronic medical record history and physical revealed Resident #1 is an [AGE] year-old, female with a history of hypertension, pressure ulcer of sacral region, chronic respiratory failure with hypoxia (Chronic Obstructive Pulmonary Disease), dysphagia (difficulty swallowing), and end stage renal disease (kidney failure/dialysis required for blood filtration). Record review of resident's Care Plan dated [DATE] states Resident #1 is at risk for skin breakdown/pressure ulcer/injury . On turning/repositioning program. Record review of Specialty Physician Wound Evaluation and Management Summary revealed Stage 3 sacrum pressure wound (resolved on [DATE]) for Resident #1. Electronically signed by Physician A on [DATE]. Record review of resident's Nurse 24-hour Report identified two small skin tears on sacrum on [DATE]. Record review of resident's wound management notes document a sacral pressure ulcer for [DATE], [DATE], and [DATE]. This revealed a lapse weekly documented skin checks for Resident #1 from [DATE] to [DATE]. Record review of Nursing Administration History: [DATE] to [DATE] physicians orders for wound care administration for sacrum: (Cleanse with NS or wound cleanser, pat dry, apply alginate calcium and cover with dry dressing daily.) Notes documented by LVN A and RN E from [DATE] to [DATE] Not Administered: To be done by wound nurse. Record review of LVN A progress note dated [DATE] stated wound size is 1.7 x 1.2 cm, edges black in color. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	In an interview with the facility ADON A on [DATE] at 12:56 PM she stated she was hired on [DATE] and was not assigned Resident #1, I am assigned to the 100 hall. I did round with the wound care doctor (Physician A), but I didn't see Resident #1 on the wound management log. The day that the wound was brought to my attention by ADON B it was a very flustering day . Because I was like, how could this be missed? The honest truth, I don't know. I saw wound care orders, but that's it. The terminated ADON C discovered the wound [DATE] and did not refer resident to physician monitored wound care services. In an interview with the facility ADON B on [DATE] at 1:20 PM stated she was hired on [DATE]. Resident #1 transitioned to my roster the same day I discharged her to the hospital due to her nurse notifying me of her change in condition on [DATE]. Her assigned nurse said her wound dressing was soiled and she changed it before EMS arrived on [DATE]. In a phone interview with the facility contracted wound care Physician A on [DATE] at 1:30 PM he stated he approved the telephone orders for Resident #1's sacral pressure wound requested by ADON C on [DATE] . Physician A stated, I go to the facility every Thursday. I don't recall seeing that patient because I don't have any notes or any evidence of her making it to the rounding list. Not sure why if it was forgotten or if she was out of the building. For some reason she never made it. I just approved the order through a call. I don't know why she was never on the list. When I go into the building, they give me a list of everyone, and I make sure I see everyone. If someone was supposed to be there that's not there, there's no way for me to just, out of the top of my mind, troubleshoot. Who is this person? Unless it's someone I've seen the week before, I would ask them did this person go home? Why are we not seeing this person, for whatever reason. She had told me that patient was supposed to be seen, but somehow, she was not on the list. The resident was never on the list. I'm not sure why. Record review of physician orders dated [DATE] revealed, Sacrum: cleans with Normal Saline or wound cleanser, pat dry, apply alginate calcium and cover with dry dressing daily. Electronically signed by Physician A on [DATE]. In a phone interview with the Responsible Party (RP) on [DATE] at 4:30 PM she stated, Resident #1 would call me in the middle of the night in excruciating pain. She told the nurses continually that she was an excruciating pain. One would think the nurses communicated that to somebody so somebody would have taken care of this prior to her suffering for a month in excruciating pain. I don't understand how it went on that long. In a phone interview with Resident #1's facility Primary Care Physician B on [DATE] at 10:19 AM he stated he was not aware of any of Resident #1's wounds . Record review of ER records revealed that the resident was septic, had fluid overload with shortness of breath and the resident as admitted to the ICU on [DATE] and continued to decline after discharge to hospice. The hospital advised the family not to readmit the resident back to the facility and assisted the family with finding home hospice care were the resident expired on [DATE]. In an interview with the facility with ED on [DATE] at 5:37 PM she stated that ADON C was terminated on [DATE] with License Referral and the DON was demoted to Care Plan Coordinator on [DATE]. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An Immediate Jeopardy (IJ) was identified on [DATE]. The ED was notified and provided with the IJ template on [DATE] at 5:36 PM. While the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of actual harm with the potential for more than minimal harm, due to the facility's need to implement and monitor the effectiveness of its corrective systems . The Plan of Removal (POR) was accepted on [DATE] at 1:48 PM, and indicated the following: Plan of Removal On [DATE] ADON's completed an in-service for Change of Condition using our SBAR should be completed on any change of condition. Progress Notes should be completed every shift for the next 3 days following SBAR. [DATE] [DATE] Administrator started reviewing resident 1 records, in-services were started to include Abuse, Neglect and Reporting. On [DATE] at 5:00pm ADON's started a skin sweep of all residents, any negative findings were corrected by orders added and referrals were made to Wound Physician. On [DATE] 4:40pm ADON's started an in-service with all Licensed Nurses, Med aides and C.N.A's regarding skin/wound documentation and notification in their documentation in the POC. [DATE] On [DATE] at 9:00am ADON assisted Administrator in reviewing the events our system has available. On [DATE] the new form for Pressure Sore/Stasis Ulcer was updated in the system and added to the events for the nurses to start using. In-service was started with all Licensed Nurses to complete the event when a Pressure Sore/Stasis Ulcer is present. The Braden Scale for Predicting Pressure Sore risk will be completed X4 Weeks after admissions or re-admissions. Quarterly thereafter. [DATE] The Administrator/DON will pull the Event reports daily to ensure all orders are in place and referral completed for Wound Physician to see on their next rounds. Administrator/DON will follow up after each round conducted by the physician to ensure resident was seen and orders carried out. Any negative finding will be corrected immediately. [DATE] All Licensed Nurses will be checked off for wound care for ADON's. DON/ADON's will complete observation wound care weekly for each nurse to ensure they are completing it correctly. [DATE] On [DATE] ADON's completed an in-service for Change of Condition using our SBAR should be completed on any change of condition. Progress Notes should be completed every shift for the next 3 days following SBAR. [DATE] [DATE] Administrator started reviewing resident 1 records, in-services were started to include Abuse, Neglect and Reporting. On [DATE] at 5:00pm ADON's started a skin sweep of all residents, any negative findings were corrected by orders added and referrals were made to Wound Physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455748	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Hall	2021 Shoaf Dr Irving, TX 75061

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	On [DATE] 4:40pm ADON's started an in-service with all nursing staff regarding skin/wound documentation and notification in include documentation in POC. [DATE] On [DATE] at 9:00am ADON assisted Administrator in reviewing the events our system has available. On [DATE] the new form for Pressure Sore/Stasis Ulcer was updated in the system and added to the events for the nurses to start using. In-service was started with all Licensed Nurses to complete the event when a Pressure Sore/Stasis Ulcer is present. The Braden Scale for Predicting Pressure Sore risk will be completed X 4 Weeks after admissions or re-admissions. Quarterly thereafter. [DATE] On [DATE] at 9:00am ADON assisted Administrator in reviewing the events our system has available. On [DATE] the new form for Pressure Sore/Stasis Ulcer was updated in the system and added to the events for the nurses to start using. In-service was started with all Licensed Nurses to complete the event when a Pressure Sore/Stasis Ulcer is present. The Braden Scale for Predicting Pressure Sore risk will be completed X 4 Weeks after admissions or re-admissions. Quarterly thereafter. [DATE] All Licensed Nurses will be checked off for wound care for ADON's. DON/ADON's will complete observation wound care weekly for each nurse to ensure they are completing it correctly. [DATE] Record review of facility Change in a Resident's Condition or Status Policy Statement (Revised 2021): Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, ., resident rights, etc.). 2. A significant change of condition is a major decline or improvement in the resident's status that: c. requires interdisciplinary review and/or revision to the care plan. Record review of facility Resident Rights Policy Statement (Revised 2016): Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation; 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: f. communication with and access to people and services, both inside and outside the facility. Monitoring of POR Record review of the facility's In-service dated [DATE] completed by facility ADON's for Change of Condition using Situation, Background, Assessment, and Recommendation (SBAR). Record review of the facility's In-Service dated [DATE] completed by ADON's regarding skin/wound documentation and notification in their documentation in the Point of Contact (POC). Record review of Plan of Correction (internal for facility) provided by ED, [NAME]- The Administrator/DON will pull the Event reports daily to ensure all orders are in place and referral completed for Wound Physician to see on their next rounds. Administrator/DON will follow up after each round conducted by the physician to ensure resident was seen and orders carried out. Any negative finding will be corrected immediately. ADON assisted Administrator in reviewing the events our system has available. On [DATE] the new form for Pressure Sore/Stasis Ulcer was updated in the system and added to the events for the nurses to start using. In-service was started with all Licensed Nurses to complete the event when a Pressure Sore/Stasis Ulcer is present. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455748	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashford Hall	2021 Shoaf Dr Irving, TX 75061

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The Braden Scale for Predicting Pressure Sore risk will be completed X 4 Weeks after admissions or re-admissions. Quarterly thereafter. All Licensed Nurses will be checked off for wound care for ADON's. DON/ADON's will complete observation wound care weekly for each nurse to ensure they are completing it correctly. (Signed by the ED) Record review of the facility's Change in Condition Policy (copied for evidence) - No concerns noted. Interviews were conducted on [DATE] at various times to include staff from various shifts. Interviews with ED, CNA A, CNA B, CMA A, LVN B, RN A, RN B, RN C, RN D, ADON A, ADON B to verify the in-services were conducted and to validate the staffs understanding of the trainings for Abuse, Neglect , and Exploitation, the importance skin/wound documentation and notification in their documentation in the Point of Contact. No concerns were found regarding the understanding of the requirements, training materials or expectations. All interviewed staff were able to communicate their understanding and proficiency of the in-services. On [DATE] at 12:50 PM Investigator notified ED the immediacy was removed and conducted the exit. Immediate Jeopardy (IJ) was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a lowered severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy and a scope of pattern as the facility continued to monitor the implementation and effectiveness of their plan of removal.