

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44405</b></p> <p>Based on observation, interview, and record review, the facility failed to identify and provide needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for 2 of 8 residents (Resident #1) reviewed for Quality of Care.</p> <p>Cumulative effects of LVN A's and MA V's individual failures to provide oversight of care delivery on 03/25/24, Resident #1 had an unwitnessed fall and sustained bruising, swelling, and an abrasion to the frontal scalp.</p> <p>The facility failed to implement interventions for Resident #1 identified as a fall risk on 12/05/22 to observe frequently and place in supervised area when out of bed (Start date 12/23/22). Resident #1 sustained unwitnessed falls in the dining room from the wheelchair on 03/14/24, 03/23/24, 03/28/24 and 04/03/24; a fall on 04/01/24 was documented as witnessed. Resident #1 had 46 documented falls since 12/05/22.</p> <p>The facility failed to ensure residents were protected from physical and psychosocial harm during abuse or neglect investigations. Resident #1 had an unwitnessed fall on 03/28/24 and a witnessed wall on 04/01/24. Resident #2 had an unwitnessed fall on 03/28/24.</p> <p>An Immediate Jeopardy (IJ) was identified on 04/01/24. The IJ template was provided to the facility on [DATE] at 4:30 PM. While the IJ was lowered on 04/04/24, the facility remained out of compliance at a scope of Pattern and severity level of No actual harm with potential for more than minimal harm that is not immediate jeopardy, due to the facility continuing to monitor the implementation and effectiveness of the corrective systems.</p> <p>The facility failed to oversee the implementation of resident care policies. LVN M failed to assess, evaluate, and obtain vital signs after Resident #1 fell on [DATE] per the facility's policy and procedure, Assessing Falls and Their Causes, revised March 2018.</p> <p>The facility failed to oversee the implementation of resident care policies. LVN A failed to initiate and document investigation of the accident on 03/28/24, when Resident #2 sustained an unwitnessed fall from her wheelchair in the Dining Area, per the facility's policy and procedure, Accidents and Incidents - Investigating and Reporting, revised July 2017.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>These deficient practices placed residents at considerable risk of serious injury, harm, impairment, developing complications, or death by not receiving services necessary, and a negative outcome to a resident's physical, mental, or psychosocial health or well-being.</p> <p>Findings included:</p> <p>Record review of the nursing schedule dated 03/25/24 revealed LVN L, CNA T, CNA J, and CNA U worked the 6A - 2P shift; MA V worked 7A - 7P. CNA W had Unpaid Time Off and CNA X was a No call, No Show; LVN A, CNA P, and CNA Q worked the 2P - 10P shift. CNA S had an excused call off.</p> <p>Resident #1</p> <p>Record review of Resident #1's Continuity of Care Document, created 03/30/24, reflected a 94 y.o. male, who admitted to the facility on [DATE] from a long-term care facility. The latest return to the facility was on 03/04/23 after a short-term acute care hospital inpatient stay with the diagnosis of Displaced fracture of base of neck of left femur. Resident #1 had a history of Repeated falls (effective date: 03/04/23); Localized swelling, mass and lump, head (effective date 03/25/24); Anxiety; COPD; unsteadiness on feet; other abnormalities of gait and mobility; dementia; and other lack of coordination.</p> <p>Record review of Resident #1's Annual MDS review assessment, dated 01/10/24, revealed Resident #1 had a severe cognitive impairment per staff assessment because a BIMS interview was not conducted. Resident #1's functional status required one-person extensive assistance with ADLs and a wheelchair for mobility.</p> <p>Record review of Resident #1's Comprehensive Care Plan, date initiated 05/31/23, reflected:</p> <p>Resident #1 had Frequent falls due to unsteady gait, family not allowing wheelchair, in a geri-chair, he slides from the geri-chair, and he tries to walk by self . The intervention(s) included Try and put to bed (Start date 02/19/24); involve in activities (Start date 01/16/24, 11/27/23, and 11/06/23); recline wheelchair (Start date 10/30/23); Replace Dycem in the wheelchair (start date 10/24/23); will have leg rests replaced on the wheelchair (Start date 10/15/23; will be provided a Scoop mattress on bed (Start date 10/09/23); will be provided a fall mat at bed side while in bed (Start date 09/25/23); and bed will be kept in the lowest position while in bed (Start date 09/25/23). The long-term goal indicated Resident #1 will not have no injuries from falls that require hospitalization in next 90 days (Target date: 05/04/24).</p> <p>Resident #1 had Potential risk for injury due to poor safety awareness. The intervention(s) included Dycem added to wheelchair (start date 01/12/23); Encourage [Resident #1] to request needed assistance in all transfers, keep call light in reach, wedge cushion to wheelchair. (Start date 01/11/23); and [Resident #1] to call for assistance with all transfers (Start date 01/11/23). The long-term goal indicated Resident #1 will be free from injury and will have safe transfers (Target date: 05/04/24).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Resident #1 experienced a fall. 12/31/22. had two additional falls. 02/28/23 Injury fall. unwitnessed fall 03/15/23 . The intervention(s) included bed in lowest position to prevent falls (Start date 03/15/23); hipsters added to both hips due to frequent falls also anti-roll back brakes (Start date 01/03/23); Keep call light in reach at all times (Start date 12/23/22);and Observe frequently and place in supervised area when out of bed (Start date 12/23/22); and Provide an environment free of clutter (Start date 12/23/22). The long-term goal reflected Refer to Therapy for evaluation for treatable causes of the fall such as poor balance, muscle weakness, and poor safety awareness. (Target date: 05/04/24).</p> <p>Record review on 03/30/24 at 4:08 PM of Resident #1's Orders History (01/01/24 - 03/30/24) reflected:</p> <ul style="list-style-type: none"> <li>- Start date 03/06/23: Admit to hospice for Dx: Senile Degeneration of the brain on 03/04/23.</li> <li>- Start date 02/24/24: Resident requires secured unit due to unsafe wandering and exit seeking on 02/21/24.</li> <li>- Start date 03/14/24: Fall: Cleanse skin tear on right palm with NS and apply steri-strips dressing. Every Shift.</li> <li>- Start date 03/18/24: OT to evaluate and treat as indicated.</li> <li>- Start date 03/23/24: Cleanse skin tear on left arm palm with NS and apply dry dressing. Monitor for s/s of infection and dc when resolved.</li> <li>- Start date 03/25/24: Triple Antibiotic ointment (TAO). Apply a small amount on the affected area for 7 days. Twice A Day (7:00 AM - 10:00 AM; 5:00 PM - 7:00 PM)</li> <li>- Start date 03/26/24: Other Test: (Skull series due to fall with head injury). STAT.'</li> <li>- Start date 03/28/24: Skin Tear: Apply antibiotic ointment, cover with dressing if needed to minor cuts or skin tears until healed. Once a Day PRN.</li> <li>- Start date 03/28/24: 'Suspected head trauma neuro checks. Q15mins (x4); Q1H (x2); Q2H (x2); Q4H (x2); then, every shift (x3). [Previous orders were written on 03/14/24, 03/23/24, and 03/25/24]</li> <li>- Start date 03/30/24: 'Wound care: Forehead - Cleanse with wound cleanser and pat dry with gauze. Apply Calcium Alginate and cover with border dressing. Once a Day. 06:00 AM - 02:00 PM.'</li> </ul> <p>Record review of Resident #1's active Orders on 04/04/24 at 4:13 PM reflected:</p> <ul style="list-style-type: none"> <li>- Start date 04/01/24: Fall Interventions: Call light .; Encourage and assist resident for frequent rest periods .; Locate resident when up near station .; Toilet at regular intervals . Every Shift.</li> <li>- Start date 04/02/24: PT to evaluate and treat as indicated. LATE ENTRY effective 04/02/24</li> <li>- Start date 04/03/24: Place Dycem (multipurpose non-slip material) in wheelchair to prevent resident from sliding out. Every Shift.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>- Start date 04/04/24: Suspected head trauma neuro checks. Q4H (x2 - 1:30 AM, 5:30 AM); then, every shift Days, Evenings, Nights (x3 - End Date 04/06/24).'</p> <p>Record review of Resident #1's progress notes indicated:</p> <p>- 03/14/24 at 12:37 PM, written by LVN L, reflected, [Resident #1] had an unwitnessed fall at 12:15 PM, was found by CNA sitting on the floor in one of the female patient's room. [Resident #1] was on a wheelchair at the time of fall. [Resident #1] unable to explain what happened . skin tear at the palm of the right hand . given Morphine 20 mg/5 mL for mild pain (PRN). Intervention includes redirecting patients, patient had non-skid socks on.</p> <p>- 03/28/24 at 12:48 PM, written by ADON, reflected, [ADON] noted [Resident #1] forehead, frontal aspect with fluid filled hematoma with open abrasion to center of hematoma at this time. called and spoke with [hospice services RN] and informed of area to [Resident #1's] head with visual documents provided for review. MD aware as well with zero new orders noted. attempted to reach hospice nurse to confirm that orders had not been given to her at this time.</p> <p>- 03/28/24 at 4:03 PM, written by ADON, reflected, [ADON] noted zero response to medically necessary orders due to [Resident #1] radiology report or area to [Resident #1] head at this time. [ADON] sent message to hospice nurse and MD requesting a return call at this time.</p> <p>- 03/29/24 at 11:04 AM, written by NP, reflected, [Resident #1] seen and examined per nursing staff request for report of a fall yesterday. Noted large hematoma to mid-frontal scalp area with ecchymosis (a discoloration of the skin resulting from bleeding underneath, typically caused by bruising). denies any pain or headache but overall stays stable .</p> <p>- 04/01/24 at 8:21 PM, written by LVN A, reflected, Skull x-ray ordered for [Resident #1] r/t unwitnessed fall. Call to RP did not go through and unable to leave a voice message.</p> <p>- 04/02/24 at 7:28 AM, written by RN N, reflected, [Resident #1] refused to do skull series, notified MD, Administrator and [Resident #1] daughter aware.</p> <p>- 04/02/24 at 7:36 AM, written by RN N, reflected, [Resident #1] fell yesterday, continue on neuro checks, no delayed injuries seen. Continue to be monitored.</p> <p>- 04/03/24 at 7:51 PM, written by LVN A, reflected, At around 6:30 PM was notified by Speech Pathologist that [Resident #1] was on the floor in the dining room. Went to the dining area and found resident on the floor next to his wheelchair. Assessed resident, then put back to wheelchair with 2 persons assist. noticed [Resident #1] was able to unlock the armrest on the wheelchair and push it down, and probably slipped from the side .</p> <p>Record review of Fall Event, dated 03/23/24, linked SBAR Communication Tool (dated 03/27/24) and Resident #1's following progress notes:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>- 03/25/24 at 6:09 PM, written by LVN A, reflected, [Resident #1] had a fall at around 5:50 PM in the dining area, and hit his head on the floor . assessed and put back on wheelchair . [Resident #1] has a bump in the front of his head and is c/o pain on his head. MD notified via text message with a picture of the injured area and replied, Apply TAO bid for seven days. Hospice called and said they are sending a nurse at the facility to assess [Resident #1] . Neuro checks initiated.</p> <p>- 03/25/24 at 10:07 PM, written by LVN A, reflected, Hospice nurse did not show up . TAO applied on resident bump per MD Order, morphine 0.25 ML provided for pain. [Resident #1] currently resting on bed . in lowest position and mat on the floor. Neuro checks ongoing.</p> <p>- 03/26/24 at 12:52 PM, written by LVN L, reflected, [Resident #1] BP 96/50, HR 77 . rechecked at 12:50 PM, BP 117/70, HR 90 . on bedrest in supine position with legs elevated 8 - 12 inches until BP returns to baseline .</p> <p>- 03/26/24 at 6:45 PM, written by LVN A, reflected, Skull x-ray done at around 6:15 PM. Result pending.</p> <p>- 03/27/24 at 6:31 AM, written by RN O, reflected, Post fall day 2/3. [Resident #1] has a decreased in his blood pressure reading. legs were elevated 8 inches and offered fluids . Fall preventive measure implemented.</p> <p>- 03/27/24 at 9:13 AM, written by LVN L, reflected, [Resident #1's] x-ray results . significant findings and head CT suggested . sent to MD and hospice nurse. [Resident #1] sent to hospital accompanied by facility driver at 9:00 AM.</p> <p>Record review of the Fall Event dated 03/25/24, LVN A indicated the fall was NOT witnessed. [Resident #1] complained of pain 3 out of 10 [4 out of 10 = Moderate Pain - Distressing, Miserable] (to his head). Injury to the head was a bump . Resident has a bump in the front of his head and is c/o pain on his head. MD notified via text message with a picture of the injured area and replied Apply TAO (an ointment that prevent infection and aids in healing of minor cuts, scrapes, and burns) BID (twice daily) for seven days. The following progress notes were linked to the Fall Event:</p> <p>- 03/19/24 at 12:56 PM, written by PCP, reflected, GDR ordered to change Ambien to PRN for 14 days, Ativan changed to AM and HS (at bedtime) per pharmacist recommendation.</p> <p>- 03/28/24 at 12:44 PM, written by ADON, reflected, [ADON] noted [Resident #1's] CT Scan results . notified PCP of available results with impressions that indicated Advance chronic microvascular ischemic changes (brain condition cause problems with thinking, walking and mood after an injury) and moderate generalized volume loss (associated with major neurological diseases, such as a large stroke or progressive dementia) noted. Ventriculomegaly (a condition in which the brain ventricles, or fluid-filled cavities, are enlarged due to build up of cerebrospinal fluid [CSF] found with moderate or severe traumatic brain injury) . hospice requested results fax . [ADON] sent fax .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of video surveillance dated 03/25/24, provided by the NFA, revealed the Dining Area. A Med Aide was against the wall standing behind the medication cart approximately 5 - 6 feet in front and to the right of Resident #1 in his high back wheelchair. The Med Aid did not have a direct line of sight of Resident #1. LVN A was approximately 15 - 20 feet away, assisting a resident with eating. Resident #1 was in LVN A's direct line of sight. Resident #1 was scooting in his wheelchair, but unable to move forward past a table and chair. It appeared that there was an object that prevented him from moving forward. Resident #1 reached towards the table on his left side to try and propel forward but could only turn left. Resident #1 turned to the left twice. Resident #1's back was to the camera when it was noted that he fell forward out of the chair hitting his face/head on the floor. The Med Aide and LVN A looked up from what they were doing 4 - 5 seconds after Resident #1 fell . LVN A walked towards Resident #1 and the MA left from behind the medication cart and headed towards the hall away from the Dining Area, where the nurses' station was located. The video clip ended.</p> <p>Record review of Fall Event dated 03/28/24 indicated Resident #1 had an unwitnessed fall at 8:16 PM in the Dining Room. The event details stated Resident #1 went to Station 5 just prior to the fall. Resident #1's following progress notes were linked to the Fall Event:</p> <p>- 03/28/24 at 8:27 PM, written by LVN A, reflected, [Resident #1] found on the floor at around 7:35 PM, in the dining room. Resident was assessed and put back on wheelchair with 3-person assist. skin tear observed on [Resident #1] right hand and behind the right ear.</p> <p>Record review of Fall Event dated 04/01/24 indicated Resident #1 had a witnessed fall in the Dining Room. The following progress notes were linked to the Fall Event:</p> <p>- 04/01/24 at 11:43 AM, written by LVN M, reflected, [Resident #1] fall in the dining room with witness during Chaplain. immediately went to the dining room, observed resident sitting down on the floor by wheelchair. Assessment done and 2-person assist resident back in chair.</p> <p>- 04/01/24 at 2:26 PM, written by NFA, reflected, Administrator spoke with Director of Hospice Services to discuss plan of care for [Resident #1] related to falls. Administrator explained that per our Rehab Manager we requested Therapy services to be given to [Resident #1] to assist in reducing falls. Director agreed. She will schedule with their therapy department to schedule therapy services to be provided to [Resident #1] She will provide [NFA] an updated plan of care for [Resident #1] and we will continue to be aware of any further changes.</p> <p>- 04/01/24 at 2:42 PM, written by NFA, reflected, Update: Spoke with Director of Hospice Services, we will have our Therapy Department to treat resident to assist in reducing [Resident #1] falls. Once that is completed we will update Plan of Care.</p> <p>Record review of Fall Event dated 04/03/24 indicated Resident #1 had an unwitnessed fall from his wheelchair in the Dining Room at 7:21 PM. Neuro checks were initiated.</p> <p>A record review of hospital medical records for 03/27/24 reflected [Resident #1] arrived at the emergency department (ED) in a wheelchair on 03/27/24 at 09:04 AM. ED triage notes indicated [Resident #1] presented to the ED after a fall and need for imaging. [SNF staff] stated [Resident #1] fell the other day and got an x-ray yesterday (03/26/24) that showed possible right temporal bone nondisplaced fracture. [Resident #1] denied pain.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A review of the ED physician physical exam on 03/27/24 at 10:06 AM revealed Large ecchymosis to the frontal parietal bone with an abrasion but no active bleeding . Review of medical assessment and plan dated 03/27/24 at 11:00 AM indicated final diagnoses Head Trauma. CT Scan without Contrast resulted Advance chronic microvascular ischemic changes (brain condition cause problems with thinking, walking and mood after an injury) and moderate generalized volume loss (associated with major neurological diseases, such as a large stroke or progressive dementia) noted. Ventriculomegaly (a condition in which the brain ventricles, or fluid-filled cavities, are enlarged due to build up of cerebrospinal fluid [CSF] found with moderate or severe traumatic brain injury). A review of the ED provider note entered on 03/27/24 at 12:15 PM reflected Blood pressure has been low, however [Resident #1's daughter] stated that it has been low since Monday (03/25/24) . [Resident #1] is on hospice at the nursing home. She [Resident #1's daughter] does not want [hospice] revoked and does not want further testing at this time . nursing home had a plan, and they are following it .</p> <p>[Resident #1] was discharged from the ED on 03/27/24 at 12:16 PM.</p> <p>Record review of video surveillance dated 04/01/24, revealed Resident #1 in the Dining Area propelling in his wheelchair toward the vending machine. There was a Medication Aide with back against the wall standing at a medication cart preparing and crushing medications (approximately 20 feet away from where Resident #1 fell ) . 7 - 8 other residents noted in the Dining Area participated in an activity (with the Chaplain) in the center of the Dining Area. There was a pressure relief pad in the seat of [Resident #1's] wheelchair and a balled-up sheet between Resident #1 and the left arm of the wheelchair. Resident #1 scooted forward to the edge of the seat, placed his right hand on the vending machine and tried to stand. A Dycem non-slip mat was not in place [reflected as an intervention in the care plan]. Resident #1 could not stand, his knees lowered to the floor, and when tried to sit back in the wheelchair, it rolled backwards. Resident #1 fell sideways on his right side, rolled over onto his back, reached out, grabbed, and pulled the wheelchair forward. Resident #1's right foot was in the gap between the left wheel and the body of the wheelchair. Resident #1 rolled over to the right side, slowly raised his upper body, and rolled back over to his right side. The Medication Aide looked up and walked towards Resident #1. LVN M was seen stepping into the Dining Area from the hall. LVN M did not assess or evaluate Resident #1's vital signs, range of motion, or inspect for any injury before the Resident #1 was assisted back into the wheelchair by the Medication Aide and LVN M. The video clip ended.</p> <p>Record review of video surveillance dated 04/03/24, revealed Resident #1 sitting at a table in the Dining Area. There was no staff present. A staff in light blue scrubs was observed coming from out the hallway into the Dining Area, approached Resident #1 and then walked away. Resident #1 attempted to stand up. Resident #1 fell backwards onto his back. An individual entered from the secured doors, noted Resident #1 on the floor and headed towards the hall where the nurses' station was located. The video clip ended.</p> <p>During an observation on 03/30/24 between 2:00 PM - 3:00 PM, Resident #1 was observed resting quietly in a right lateral laying position in bed. Bed in the lowest position, flushed to wall with scoop mattress (edges are raised higher than the mattress center). A fall mat was noticed on the opposite side of the room away from bed. Call light on floor under the foot of the bed. There was one nurse and one CNA observed in the secured unit.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/30/24 at 3:00 PM, RN D stated he was the assigned nurse for Resident #1. RN D stated that he worked weekends double shifts (6A - 2P and 2P - 10P). RN D stated he placed Resident #1 to bed. RN D said that he pulled the fall mat away from the bed to assist Resident #1 to bed from the wheelchair (high back wheelchair next to the bed, pressure-relieving pad in place, no Dycem mat noted) and did not place the fall mat next to the bed. RN D picked the call light up from under the foot of the bed and placed within Resident #1's reach. RN D said that there were two nurses and three CNAs assigned to the secured unit, however he and one CNA were the only staff currently in the secured unit while the other nurse and two CNAs attended an in-service. RN D said that a resident is at risk for harm if care plan interventions were not implemented appropriately or timely. RN D said that interventions in place for Resident #1 to prevent falls included bed in lowest position, to use the call light for help, to place call light within reach, and to place the fall mat at the bedside when Resident #1 was in bed. RN D said he was not present when Resident #1 sustained a fall on 03/25/24. RN D said that Resident #1 had multiple falls and tried to keep [Resident #1] within line of sight or interact during activities to prevent falls. RN D said that Resident #1 required frequent redirection and attention to prevent falls.</p> <p>During an interview on 03/30/24 at 4:55 PM, the NFA stated she was still investigating the incident when Resident #1 fell on [DATE]. The NFA stated that staff must notify her immediately of any incident or accident. The NFA said if an unusual incident (possible resident abuse, neglect, mistreatment and/or unwitnessed injuries) was reported, she immediately reviewed the surveillance cameras to gather information about individuals involved and determine if staff followed protocol when reacted to an accident or incident. The NFA stated that she first learned on 03/27/24 about Resident #1's head injury sustained from a fall (on 03/25/24) and completed a facility incident self-report on-line. The NFA indicated that she did not see staff or another resident push or cause Resident #1 to fall and neglect was not identified.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/30/24 at 5:47 PM, the ADON indicated Resident #1 . still wants to be independent . will not ask for help. The ADON stated Resident #1 was wheelchair bound and should remain within the staff line of sight in the Dining Area to prevent falls. The ADON said there were signs posted for Resident #1 to use the call light for assistance and the wheelchair and bed lowered to prevent falls. The ADON said that Resident #1 had a fall on Monday (03/25/24) evening. The ADON said she had already left for the day when LVN A called to notify that Resident #1 had a fall and reported that he did not complain of pain and there was no injury. LVN A reported to the ADON that Resident #1 was sitting at the nurses' station and the hospice on-call nurse was notified to come assess Resident #1. The ADON said that she assessed and evaluated Resident #1 the next day (03/26/24) when she returned to work. The ADON said that she discovered a raised bump on Resident #1 forehead with an abrasion that appeared shiny where a generous amount of ointment was applied. The ADON said that she asked LVN A about the injury and what actions were taken. LVN A told the ADON that she [LVN A] texted the PCP about the fall and applied the ointment [TAO] as ordered, then notified the hospice on-call nurse, but she never showed. The ADON said that she explained to LVN A that the facility was Resident #1's primary caregiver and immediate actions should be taken when a resident sustained an apparent head injury. The ADON said that she immediately called the PCP and requested orders for a skull x-ray and labs. The ADON said she implemented the orders right away. The ADON said that she reviewed the Skull x-ray results the next morning (03/27/24). The results suggested a CT scan because a skull fracture could not be ruled out by the images. ADON said that Resident #1 was sent to the hospital accompanied by the facility van driver via the facility van. The ADON stated that she expected nurses to conduct rounds minimally every two hours and as needed, or more frequent for residents who were a high fall risk. The ADON indicated keeping residents within the line of sight and not alone in their rooms if the resident tried to act beyond their level of function. Additionally, the ADON stated that nurses should check that fall precautions were in place, residents are wearing non-slip socks or appropriate slippers/shoes, positioning, if the resident is in pain, or assist to the restroom during rounds.</p> <p>Record review of the text communication sent to the MD from LVN A when Resident #1 fell on [DATE] and hit his head indicated, . Resident #1 had a fall in the Dining Area and hit his head on the floor . complaining of pain on his head. He is alert. Hospice notified. LVN A attached a picture of Resident #1's head injury to the communication that revealed a raised area on the frontal region of [Resident #1's] scalp. A light purplish-blue discoloration surrounded the raised area. There was a reddened scraped area at the middle of the raised area. The reply from the MD stated, Apply TAO BID for seven days.</p> <p>During an observation on 04/01/24 at 1:29 PM, Resident #1 was observed in a high back wheelchair propelling with his feet only, grabbing and pushing chairs out of the pathway. Resident #1 leaned forward trying to reach a sandwich from under a chair. Dycem material was not observed under Resident #1 on the seat of the wheelchair. The ADON observed Resident #1 leaning forward and went to his side to assist upright in wheelchair. When the ADON walked away, Resident #1 tried to stand up. The ADON came back over to Resident #1, assisted and repositioned Resident #1 back into an appropriate upright position in wheelchair. The ADON gave verbal reminders not to stand up or try to transfer from the wheelchair without assistance. The ADON asked a CNA to frequently observe and supervise Resident #1 while in the Dining Area. The ADON rearranged the chairs back to the tables and cleared a pathway around the tables in the Dining Area. A conversation was overheard between a nurse and the NFA that Resident #1 had a fall in the morning (04/01/24).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/01/24 at 4:40 PM, LVN A indicated that she worked on 03/25/24, 03/28/24, and 04/03/24, 2P - 10P shift. LVN A stated that she was assigned to Resident #1. LVN A stated that Resident #1 had unwitnessed falls on those days that she worked. LVN A stated that Resident #1 needed one-to-one supervision to prevent falls and that was not possible with 5 staff and 30 or more residents that were fall risks, required incontinent care, or demonstrated behaviors that may harm another resident. LVN A stated that she notified the MD by text about Resident #1's fall (on 03/25/24). LVN A said that she texted the MD that Resident #1 hit his head on the floor, complained of pain, that he [Resident #1] was alert, and attached a picture of Resident #1's head injury to the text. LVN A said that alert indicated that Resident #1 did not lose consciousness. LVN A said that the MD replied by text to apply TAO to the abrasion. LVN A stated that she would assess and evaluate a resident by checking vital signs, range of motion of extremities (by asking the resident to move their extremities and then moving the resident extremity), asked about pain, and look for any bruises or injuries. LVN A said that she was not sure if Resident #1 had a fall in the morning, she was not present. LVN A said that she was supposed to initiate a Fall Event report for every accident or incident. LVN A said that it was her responsibility to check on residents every two hours alternating with the CNAs to ensure resident safety, interventions were in place, and acknowledge whereabouts.</p> <p>During an observation and interview on 04/01/24 at 4:45 PM, the OT assisted Resident #1 from the high back wheelchair to a smaller blue wheelchair. The OT assessed and evaluated Resident #1's comfort in the chair. The OT pushed Resident #1 in the wheelchair to the Dining Area and tilted the wheelchair back enough to raise Resident #1's feet off the floor. The OT conducted a visual observation of Resident #1 in the wheelchair. During an interview, the OT stated that occupational therapy was consulted on 04/01/24 to assess and evaluate Resident #1 after multiple falls. The OT indicated that the blue wheelchair was called a tilt-in-space. The OT stated the purpose of the wheelchair was to easily reposition Resident #1 when sitting in the wheelchair to prevent falls and maintain posture when in the reclined position. The OT stated the tilt-in-space wheelchair could reduce falls; however, when in the reclined position Resident #1 could not freely propel and move about in the wheelchair.</p> <p>During an interview on 04/01/24 at 5:15 PM, the DOR indicated that Resident #1 was currently on service with occupational therapy after assessment and evaluation related to a fall Resident #1 had on 03/18/24. The DOR stated therapy was consulted [04/01/24] for reassessment of Resident #1 due to frequent falls. The DOR indicated supervised stand-by assistance would be an effective intervention for Resident #1 to prevent falls.</p> <p>Record review of an undated typed Incident Narrative revealed the MD name, address, and contact information in the heading. The Incident Narrative indicated Resident #1 resided at the SNF and was under the MD care. The Incident Narrative described Resident #1 was also a hospice patient . required assistance with ADLs, was non-ambulatory, incontinent of bowel and bladder, had extensive muscle wasting and deconditioning. The Incident Narrative indicated Due to his severe dementia . is unaware cannot walk, repeatedly stands from his wheelchair or bed, and immediately falls, which he has done multiple times. In the body of the Incident Narrative revealed [Resident #1] fell on [DATE], . sustained a superficial abrasion of the scalp in the forehead area. notified by nursing staff and ordered antibiotic to the abrasion. There was no evidence of any brain injury or neurological changes such as seizure, coma, mental status changes. The following day . developed a hematoma around the abrasion area, and determined at that time that a skull x-ray was indicated and ordered . The Incident Narrative closed with a statement of the MD's initial impression was confirmed when Resident #1 returne [TRUNCATED]</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44405</p> <p>Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 2 of 8 residents (Resident #1) reviewed for accidents and supervision.</p> <p>The facility failed to ensure adequate supervision for residents identified as a fall risk. Resident #1 sustained a skin tear to the right inner wrist on 03/14/24, a skin tear on the left inner wrist on 03/23/24, and sustained head trauma from an unwitnessed fall on 03/25/24. Resident #2 sustained blunt head trauma and a laceration above the left eyebrow from an unwitnessed fall on 03/09/24.</p> <p>The facility failed to implement effective care plan interventions for residents identified as a fall risk.</p> <p>An Immediate Jeopardy (IJ) was identified on 04/01/24. The IJ template was provided to the facility on [DATE] at 4:30 PM. While the IJ was lowered on 04/04/24, the facility remained out of compliance at a scope of Pattern and severity level of No actual harm with potential for more than minimal harm that is not immediate jeopardy, due to the facility continuing to monitor the implementation and effectiveness of the corrective systems.</p> <p>The facility failed to oversee the implementation of resident care policies. LVN M failed to assess, evaluate, and obtain vital signs after Resident #1 fell on [DATE] per the facility's policy and procedure, Assessing Falls and Their Causes, revised March 2018.</p> <p>The facility failed to oversee the implementation of resident care policies. LVN A failed to initiate and document investigation of the accident on 03/28/24, when Resident #2 sustained an unwitnessed fall from her wheelchair in the Dining Area, per the facility's policy and procedure, Accidents and Incidents - Investigating and Reporting, revised July 2017.</p> <p>These deficient practices placed residents at considerable risk of serious injury, harm, impairment, developing complications, or death by not receiving services necessary, and a negative outcome to a resident's physical, mental, or psychosocial health or well-being.</p> <p>Findings included:</p> <p>Resident #1</p> <p>Record review of Resident #1's Continuity of Care Document, created 03/30/24, reflected a 94 y.o. male, who admitted to the facility on [DATE] from a long-term care facility. The latest return to the facility was on 03/04/23 after a short-term acute care hospital inpatient stay with the diagnosis of Displaced fracture of base of neck of left femur. Resident #1 had a history of Repeated falls (effective date: 03/04/23); Localized swelling, mass and lump, head (effective date 03/25/24); Anxiety; COPD; unsteadiness on feet; other abnormalities of gait and mobility; dementia; and other lack of coordination.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's Annual MDS review assessment, dated 01/10/24, revealed Resident #1 had a severe cognitive impairment per staff assessment because a BIMS interview was not conducted. Resident #1's functional status required one-person extensive assistance with ADLs and a wheelchair for mobility.</p> <p>Record review of Resident #1's Comprehensive Care Plan, date initiated 05/31/23, reflected:</p> <p>Resident #1 had Frequent falls due to unsteady gait, family not allowing wheelchair, in a geri-chair, he slides from the geri-chair, and he tries to walk by self . The intervention(s) included Try and put to bed (Start date 02/19/24); involve in activities (Start date 01/16/24, 11/27/23, and 11/06/23); recline wheelchair (Start date 10/30/23); Replace Dycem in the wheelchair (start date 10/24/23); will have leg rests replaced on the wheelchair (Start date 10/15/23; will be provided a Scoop mattress on bed (Start date 10/09/23); will be provided a fall mat at bed side while in bed (Start date 09/25/23); and bed will be kept in the lowest position while in bed (Start date 09/25/23). The long-term goal indicated Resident #1 will not have no injuries from falls that require hospitalization in next 90 days (Target date: 05/04/24).</p> <p>Resident #1 had Potential risk for injury due to poor safety awareness. The intervention(s) included Dycem added to wheelchair (start date 01/12/23); Encourage [Resident #1] to request needed assistance in all transfers, keep call light in reach, wedge cushion to wheelchair. (Start date 01/11/23); and [Resident #1] to call for assistance with all transfers (Start date 01/11/23). The long-term goal indicated Resident #1 will be free from injury and will have safe transfers (Target date: 05/04/24).</p> <p>Resident #1 experienced a fall. 12/31/22. had two additional falls. 02/28/23 Injury fall. unwitnessed fall 03/15/23 . The intervention(s) included bed in lowest position to prevent falls (Start date 03/15/23); hipsters added to both hips due to frequent falls also anti-roll back brakes (Start date 01/03/23); Keep call light in reach at all times (Start date 12/23/22);and Observe frequently and place in supervised area when out of bed (Start date 12/23/22); and Provide an environment free of clutter (Start date 12/23/22). The long-term goal reflected Refer to Therapy for evaluation for treatable causes of the fall such as poor balance, muscle weakness, and poor safety awareness. (Target date: 05/04/24).</p> <p>Record review on 03/30/24 at 4:08 PM of Resident #1's Orders History (01/01/24 - 03/30/24) reflected:</p> <ul style="list-style-type: none"> <li>- Start date 03/06/23: Admit to hospice for Dx: Senile Degeneration of the brain on 03/04/23.</li> <li>- Start date 02/24/24: Resident requires secured unit due to unsafe wandering and exit seeking on 02/21/24.</li> <li>- Start date 03/14/24: Fall: Cleanse skin tear on right palm with NS and apply steri-strips dressing. Every Shift.</li> <li>- Start date 03/18/24: OT to evaluate and treat as indicated.</li> <li>- Start date 03/23/24: Cleanse skin tear on left arm palm with NS and apply dry dressing. Monitor for s/s of infection and dc when resolved.</li> </ul> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>- Start date 03/25/24: Triple Antibiotic ointment (TAO). Apply a small amount on the affected area for 7 days. Twice A Day (7:00 AM - 10:00 AM; 5:00 PM - 7:00 PM)</p> <p>- Start date 03/26/24: Other Test: (Skull series due to fall with head injury). STAT.'</p> <p>- Start date 03/28/24: Skin Tear: Apply antibiotic ointment, cover with dressing if needed to minor cuts or skin tears until healed. Once a Day PRN.</p> <p>- Start date 03/28/24: 'Suspected head trauma neuro checks. Q15mins (x4); Q1H (x2); Q2H (x2); Q4H (x2); then, every shift (x3). [Previous orders were written on 03/14/24, 03/23/24, and 03/25/24]</p> <p>- Start date 03/30/24: 'Wound care: Forehead - Cleanse with wound cleanser and pat dry with gauze. Apply Calcium Alginate and cover with border dressing. Once a Day. 06:00 AM - 02:00 PM.'</p> <p>Record review of Resident #1's active Orders on 04/04/24 at 4:13 PM reflected:</p> <p>- Start date 04/01/24: Fall Interventions: Call light .; Encourage and assist resident for frequent rest periods .; Locate resident when up near station .; Toilet at regular intervals . Every Shift.</p> <p>- Start date 04/02/24: PT to evaluate and treat as indicated. LATE ENTRY effective 04/02/24</p> <p>- Start date 04/03/24: Place Dycem (multipurpose non-slip material) in wheelchair to prevent resident from sliding out. Every Shift.</p> <p>- Start date 04/04/24: Suspected head trauma neuro checks. Q4H (x2 - 1:30 AM, 5:30 AM); then, every shift Days, Evenings, Nights (x3 - End Date 04/06/24).'</p> <p>Record review of Resident #1's progress notes indicated:</p> <p>- 03/14/24 at 12:37 PM, written by LVN L, reflected, [Resident #1] had an unwitnessed fall at 12:15 PM, was found by CNA sitting on the floor in one of the female patient's room. [Resident #1] was on a wheelchair at the time of fall. [Resident #1] unable to explain what happened . skin tear at the palm of the right hand . given Morphine 20 mg/5 mL for mild pain (PRN). Intervention includes redirecting patients, patient had non-skid socks on.</p> <p>- 03/28/24 at 12:48 PM, written by ADON, reflected, [ADON] noted [Resident #1] forehead, frontal aspect with fluid filled hematoma with open abrasion to center of hematoma at this time. called and spoke with [hospice services RN] and informed of area to [Resident #1's] head with visual documents provided for review. MD aware as well with zero new orders noted. attempted to reach hospice nurse to confirm that orders had not been given to her at this time.</p> <p>- 03/28/24 at 4:03 PM, written by ADON, reflected, [ADON] noted zero response to medically necessary orders due to [Resident #1] radiology report or area to [Resident #1] head at this time. [ADON] sent message to hospice nurse and MD requesting a return call at this time.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>- 03/29/24 at 11:04 AM, written by NP, reflected, [Resident #1] seen and examined per nursing staff request for report of a fall yesterday. Noted large hematoma to mid-frontal scalp area with ecchymosis (a discoloration of the skin resulting from bleeding underneath, typically caused by bruising). denies any pain or headache but overall stays stable .</p> <p>- 04/01/24 at 8:21 PM, written by LVN A, reflected, Skull x-ray ordered for [Resident #1] r/t unwitnessed fall. Call to RP did not go through and unable to leave a voice message.</p> <p>- 04/02/24 at 7:28 AM, written by RN N, reflected, [Resident #1] refused to do skull series, notified MD, Administrator and [Resident #1] daughter aware.</p> <p>- 04/02/24 at 7:36 AM, written by RN N, reflected, [Resident #1] fell yesterday, continue on neuro checks, no delayed injuries seen. Continue to be monitored.</p> <p>- 04/03/24 at 7:51 PM, written by LVN A, reflected, At around 6:30 PM was notified by Speech Pathologist that [Resident #1] was on the floor in the dining room. Went to the dining area and found resident on the floor next to his wheelchair. Assessed resident, then put back to wheelchair with 2 persons assist. noticed [Resident #1] was able to unlock the armrest on the wheelchair and push it down, and probably slipped from the side .</p> <p>Record review of Fall Event, dated 03/23/24, linked SBAR Communication Tool (dated 03/27/24) and Resident #1's following progress notes:</p> <p>- 03/25/24 at 6:09 PM, written by LVN A, reflected, [Resident #1] had a fall at around 5:50 PM in the dining area, and hit his head on the floor . assessed and put back on wheelchair . [Resident #1] has a bump in the front of his head and is c/o pain on his head. MD notified via text message with a picture of the injured area and replied, Apply TAO bid for seven days. Hospice called and said they are sending a nurse at the facility to assess [Resident #1] . Neuro checks initiated.</p> <p>- 03/25/24 at 10:07 PM, written by LVN A, reflected, Hospice nurse did not show up . TAO applied on resident bump per MD Order, morphine 0.25 ML provided for pain. [Resident #1] currently resting on bed . in lowest position and mat on the floor. Neuro checks ongoing.</p> <p>- 03/26/24 at 12:52 PM, written by LVN L, reflected, [Resident #1] BP 96/50, HR 77 . rechecked at 12:50 PM, BP 117/70, HR 90 . on bedrest in supine position with legs elevated 8 - 12 inches until BP returns to baseline .</p> <p>- 03/26/24 at 6:45 PM, written by LVN A, reflected, Skull x-ray done at around 6:15 PM. Result pending.</p> <p>- 03/27/24 at 6:31 AM, written by RN O, reflected, Post fall day 2/3. [Resident #1] has a decreased in his blood pressure reading. legs were elevated 8 inches and offered fluids . Fall preventive measure implemented.</p> <p>- 03/27/24 at 9:13 AM, written by LVN L, reflected, [Resident #1's] x-ray results . significant findings and head CT suggested . sent to MD and hospice nurse. [Resident #1] sent to hospital accompanied by facility driver at 9:00 AM.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of the Fall Event dated 03/25/24, LVN A indicated the fall was NOT witnessed. [Resident #1] complained of pain 3 out of 10 [4 out of 10 = Moderate Pain - Distressing, Miserable] (to his head). Injury to the head was a bump . Resident has a bump in the front of his head and is c/o pain on his head. MD notified via text message with a picture of the injured area and replied Apply TAO (an ointment that prevent infection and aids in healing of minor cuts, scrapes, and burns) BID (twice daily) for seven days. The following progress notes were linked to the Fall Event:</p> <p>- 03/19/24 at 12:56 PM, written by PCP, reflected, GDR ordered to change Ambien to PRN for 14 days, Ativan changed to AM and HS (at bedtime) per pharmacist recommendation.</p> <p>- 03/28/24 at 12:44 PM, written by ADON, reflected, [ADON] noted [Resident #1's] CT Scan results . notified PCP of available results with impressions that indicated Advance chronic microvascular ischemic changes (brain condition cause problems with thinking, walking and mood after an injury) and moderate generalized volume loss (associated with major neurological diseases, such as a large stroke or progressive dementia) noted. Ventriculomegaly (a condition in which the brain ventricles, or fluid-filled cavities, are enlarged due to build up of cerebrospinal fluid [CSF] found with moderate or severe traumatic brain injury) . hospice requested results fax . [ADON] sent fax .</p> <p>Record review of video surveillance dated 03/25/24, provided by the NFA, revealed the Dining Area. A Med Aide was against the wall standing behind the medication cart approximately 5 - 6 feet in front and to the right of Resident #1 in his high back wheelchair. The Med Aid did not have a direct line of sight of Resident #1. LVN A was approximately 15 - 20 feet away, assisting a resident with eating. Resident #1 was in LVN A's direct line of sight. Resident #1 was scooting in his wheelchair, but unable to move forward past a table and chair. It appeared that there was an object that prevented him from moving forward. Resident #1 reached towards the table on his left side to try and propel forward but could only turn left. Resident #1 turned to the left twice. Resident #1's back was to the camera when it was noted that he fell forward out of the chair hitting his face/head on the floor. The Med Aide and LVN A looked up from what they were doing 4 - 5 seconds after Resident #1 fell . LVN A walked towards Resident #1 and the MA left from behind the medication cart and headed towards the hall away from the Dining Area, where the nurses' station was located. The video clip ended.</p> <p>Record review of Fall Event dated 03/28/24 indicated Resident #1 had an unwitnessed fall at 8:16 PM in the Dining Room. The event details stated Resident #1 went to Station 5 just prior to the fall. Resident #1's following progress notes were linked to the Fall Event:</p> <p>- 03/28/24 at 8:27 PM, written by LVN A, reflected, [Resident #1] found on the floor at around 7:35 PM, in the dining room. Resident was assessed and put back on wheelchair with 3-person assist. skin tear observed on [Resident #1] right hand and behind the right ear.</p> <p>Record review of Fall Event dated 04/01/24 indicated Resident #1 had a witnessed fall in the Dining Room. The following progress notes were linked to the Fall Event:</p> <p>- 04/01/24 at 11:43 AM, written by LVN M, reflected, [Resident #1] fall in the dining room with witness during Chaplain. immediately went to the dining room, observed resident sitting down on the floor by wheelchair. Assessment done and 2-person assist resident back in chair.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>- 04/01/24 at 2:26 PM, written by NFA, reflected, Administrator spoke with Director of Hospice Services to discuss plan of care for [Resident #1] related to falls. Administrator explained that per our Rehab Manager we requested Therapy services to be given to [Resident #1] to assist in reducing falls. Director agreed. She will schedule with their therapy department to schedule therapy services to be provided to [Resident #1] She will provide [NFA] an updated plan of care for [Resident #1] and we will continue to be aware of any further changes.</p> <p>- 04/01/24 at 2:42 PM, written by NFA, reflected, Update: Spoke with Director of Hospice Services, we will have our Therapy Department to treat resident to assist in reducing [Resident #1] falls. Once that is completed we will update Plan of Care.</p> <p>Record review of Fall Event dated 04/03/24 indicated Resident #1 had an unwitnessed fall from his wheelchair in the Dining Room at 7:21 PM. Neuro checks were initiated.</p> <p>A record review of hospital medical records for 03/27/24 reflected [Resident #1] arrived at the emergency department (ED) in a wheelchair on 03/27/24 at 09:04 AM. ED triage notes indicated [Resident #1] presented to the ED after a fall and need for imaging. [SNF staff] stated [Resident #1] fell the other day and got an x-ray yesterday (03/26/24) that showed possible right temporal bone nondisplaced fracture. [Resident #1] denied pain.</p> <p>A review of the ED physician physical exam on 03/27/24 at 10:06 AM revealed Large ecchymosis to the frontal parietal bone with an abrasion but no active bleeding . Review of medical assessment and plan dated 03/27/24 at 11:00 AM indicated final diagnoses Head Trauma. CT Scan without Contrast resulted Advance chronic microvascular ischemic changes (brain condition cause problems with thinking, walking and mood after an injury) and moderate generalized volume loss (associated with major neurological diseases, such as a large stroke or progressive dementia) noted. Ventriculomegaly (a condition in which the brain ventricles, or fluid-filled cavities, are enlarged due to build up of cerebrospinal fluid [CSF] found with moderate or severe traumatic brain injury). A review of the ED provider note entered on 03/27/24 at 12:15 PM reflected Blood pressure has been low, however [Resident #1's daughter] stated that it has been low since Monday (03/25/24) . [Resident #1] is on hospice at the nursing home. She [Resident #1's daughter] does not want [hospice] revoked and does not want further testing at this time . nursing home had a plan, and they are following it .</p> <p>[Resident #1] was discharged from the ED on 03/27/24 at 12:16 PM.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of video surveillance dated 04/01/24, revealed Resident #1 in the Dining Area propelling in his wheelchair toward the vending machine. There was a Medication Aide with back against the wall standing at a medication cart preparing and crushing medications (approximately 20 feet away from where Resident #1 fell ). 7 - 8 other residents noted in the Dining Area participated in an activity (with the Chaplain) in the center of the Dining Area. There was a pressure relief pad in the seat of [Resident #1's] wheelchair and a balled-up sheet between Resident #1 and the left arm of the wheelchair. Resident #1 scooted forward to the edge of the seat, placed his right hand on the vending machine and tried to stand. A Dycem non-slip mat was not in place [reflected as an intervention in the care plan]. Resident #1 could not stand, his knees lowered to the floor, and when tried to sit back in the wheelchair, it rolled backwards. Resident #1 fell sideways on his right side, rolled over onto his back, reached out, grabbed, and pulled the wheelchair forward. Resident #1's right foot was in the gap between the left wheel and the body of the wheelchair. Resident #1 rolled over to the right side, slowly raised his upper body, and rolled back over to his right side. The Medication Aide looked up and walked towards Resident #1. LVN M was seen stepping into the Dining Area from the hall. LVN M did not assess or evaluate Resident #1's vital signs, range of motion, or inspect for any injury before the Resident #1 was assisted back into the wheelchair by the Medication Aide and LVN M. The video clip ended.</p> <p>Record review of video surveillance dated 04/03/24, revealed Resident #1 sitting at a table in the Dining Area. There was no staff present. A staff in light blue scrubs was observed coming from out the hallway into the Dining Area, approached Resident #1 and then walked away. Resident #1 attempted to stand up. Resident #1 fell backwards onto his back. An individual entered from the secured doors, noted Resident #1 on the floor and headed towards the hall where the nurses' station was located. The video clip ended.</p> <p>During an observation on 03/30/24 between 2:00 PM - 3:00 PM, Resident #1 was observed resting quietly in a right lateral laying position in bed. Bed in the lowest position, flushed to wall with scoop mattress (edges are raised higher than the mattress center). A fall mat was noticed on the opposite side of the room away from bed. Call light on floor under the foot of the bed. There was one nurse and one CNA observed in the secured unit.</p> <p>During an interview on 03/30/24 at 3:00 PM, RN D stated he was the assigned nurse for Resident #1. RN D stated that he worked weekends double shifts (6A - 2P and 2P - 10P). RN D stated he placed Resident #1 to bed. RN D said that he pulled the fall mat away from the bed to assist Resident #1 to bed from the wheelchair (high back wheelchair next to the bed, pressure-relieving pad in place, no Dycem mat noted) and did not place the fall mat next to the bed. RN D picked the call light up from under the foot of the bed and placed within Resident #1's reach. RN D said that there were two nurses and three CNAs assigned to the secured unit, however he and one CNA were the only staff currently in the secured unit while the other nurse and two CNAs attended an in-service. RN D said that a resident is at risk for harm if care plan interventions were not implemented appropriately or timely. RN D said that interventions in place for Resident #1 to prevent falls included bed in lowest position, to use the call light for help, to place call light within reach, and to place the fall mat at the bedside when Resident #1 was in bed. RN D said he was not present when Resident #1 sustained a fall on 03/25/24. RN D said that Resident #1 had multiple falls and tried to keep [Resident #1] within line of sight or interact during activities to prevent falls. RN D said that Resident #1 required frequent redirection and attention to prevent falls.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/30/24 at 4:55 PM, the NFA stated she was still investigating the incident when Resident #1 fell on [DATE]. The NFA stated that staff must notify her immediately of any incident or accident. The NFA said if an unusual incident (possible resident abuse, neglect, mistreatment and/or unwitnessed injuries) was reported, she immediately reviewed the surveillance cameras to gather information about individuals involved and determine if staff followed protocol when reacted to an accident or incident. The NFA stated that she first learned on 03/27/24 about Resident #1's head injury sustained from a fall (on 03/25/24) and completed a facility incident self-report on-line. The NFA indicated that she did not see staff or another resident push or cause Resident #1 to fall and neglect was not identified.</p> <p>During an interview on 03/30/24 at 5:47 PM, the ADON indicated Resident #1 . still wants to be independent . will not ask for help. The ADON stated Resident #1 was wheelchair bound and should remain within the staff line of sight in the Dining Area to prevent falls. The ADON said there were signs posted for Resident #1 to use the call light for assistance and the wheelchair and bed lowered to prevent falls. The ADON said that Resident #1 had a fall on Monday (03/25/24) evening. The ADON said she had already left for the day when LVN A called to notify that Resident #1 had a fall and reported that he did not complain of pain and there was no injury. LVN A reported to the ADON that Resident #1 was sitting at the nurses' station and the hospice on-call nurse was notified to come assess Resident #1. The ADON said that she assessed and evaluated Resident #1 the next day (03/26/24) when she returned to work. The ADON said that she discovered a raised bump on Resident #1 forehead with an abrasion that appeared shiny where a generous amount of ointment was applied. The ADON said that she asked LVN A about the injury and what actions were taken. LVN A told the ADON that she [LVN A] texted the PCP about the fall and applied the ointment [TAO] as ordered, then notified the hospice on-call nurse, but she never showed. The ADON said that she explained to LVN A that the facility was Resident #1's primary caregiver and immediate actions should be taken when a resident sustained an apparent head injury. The ADON said that she immediately called the PCP and requested orders for a skull x-ray and labs. The ADON said she implemented the orders right away. The ADON said that she reviewed the Skull x-ray results the next morning (03/27/24). The results suggested a CT scan because a skull fracture could not be ruled out by the images. ADON said that Resident #1 was sent to the hospital accompanied by the facility van driver via the facility van. The ADON stated that she expected nurses to conduct rounds minimally every two hours and as needed, or more frequent for residents who were a high fall risk. The ADON indicated keeping residents within the line of sight and not alone in their rooms if the resident tried to act beyond their level of function. Additionally, the ADON stated that nurses should check that fall precautions were in place, residents are wearing non-slip socks or appropriate slippers/shoes, positioning, if the resident is in pain, or assist to the restroom during rounds.</p> <p>Record review of the text communication sent to the MD from LVN A when Resident #1 fell on [DATE] and hit his head indicated, . Resident #1 had a fall in the Dining Area and hit his head on the floor . complaining of pain on his head. He is alert. Hospice notified. LVN A attached a picture of Resident #1's head injury to the communication that revealed a raised area on the frontal region of [Resident #1's] scalp. A light purplish-blue discoloration surrounded the raised area. There was a reddened scraped area at the middle of the raised area. The reply from the MD stated, Apply TAO BID for seven days.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an observation on 04/01/24 at 1:29 PM, Resident #1 was observed in a high back wheelchair propelling with his feet only, grabbing and pushing chairs out of the pathway. Resident #1 leaned forward trying to reach a sandwich from under a chair. Dycem material was not observed under Resident #1 on the seat of the wheelchair. The ADON observed Resident #1 leaning forward and went to his side to assist upright in wheelchair. When the ADON walked away, Resident #1 tried to stand up. The ADON came back over to Resident #1, assisted and repositioned Resident #1 back into an appropriate upright position in wheelchair. The ADON gave verbal reminders not to stand up or try to transfer from the wheelchair without assistance. The ADON asked a CNA to frequently observe and supervise Resident #1 while in the Dining Area. The ADON rearranged the chairs back to the tables and cleared a pathway around the tables in the Dining Area. A conversation was overheard between a nurse and the NFA that Resident #1 had a fall in the morning (04/01/24).</p> <p>During an interview on 04/01/24 at 4:40 PM, LVN A indicated that she worked on 03/25/24, 03/28/24, and 04/03/24, 2P - 10P shift. LVN A stated that she was assigned to Resident #1. LVN A stated that Resident #1 had unwitnessed falls on those days that she worked. LVN A stated that Resident #1 needed one-to-one supervision to prevent falls and that was not possible with 5 staff and 30 or more residents that were fall risks, required incontinent care, or demonstrated behaviors that may harm another resident. LVN A stated that she notified the MD by text about Resident #1's fall (on 03/25/24). LVN A said that she texted the MD that Resident #1 hit his head on the floor, complained of pain, that he [Resident #1] was alert, and attached a picture of Resident #1's head injury to the text. LVN A said that alert indicated that Resident #1 did not lose consciousness. LVN A said that the MD replied by text to apply TAO to the abrasion. LVN A stated that she would assess and evaluate a resident by checking vital signs, range of motion of extremities (by asking the resident to move their extremities and then moving the resident extremity), asked about pain, and look for any bruises or injuries. LVN A said that she was not sure if Resident #1 had a fall in the morning, she was not present. LVN A said that she was supposed to initiate a Fall Event report for every accident or incident. LVN A said that it was her responsibility to check on residents every two hours alternating with the CNAs to ensure resident safety, interventions were in place, and acknowledge whereabouts.</p> <p>During an observation and interview on 04/01/24 at 4:45 PM, the OT assisted Resident #1 from the high back wheelchair to a smaller blue wheelchair. The OT assessed and evaluated Resident #1's comfort in the chair. The OT pushed Resident #1 in the wheelchair to the Dining Area and tilted the wheelchair back enough to raise Resident #1's feet off the floor. The OT conducted a visual observation of Resident #1 in the wheelchair. During an interview, the OT stated that occupational therapy was consulted on 04/01/24 to assess and evaluate Resident #1 after multiple falls. The OT indicated that the blue wheelchair was called a tilt-in-space. The OT stated the purpose of the wheelchair was to easily reposition Resident #1 when sitting in the wheelchair to prevent falls and maintain posture when in the reclined position. The OT stated the tilt-in-space wheelchair could reduce falls; however, when in the reclined position Resident #1 could not freely propel and move about in the wheelchair.</p> <p>During an interview on 04/01/24 at 5:15 PM, the DOR indicated that Resident #1 was currently on service with occupational therapy after assessment and evaluation related to a fall Resident #1 had on 03/18/24. The DOR stated therapy was consulted [04/01/24] for reassessment of Resident #1 due to frequent falls. The DOR indicated supervised stand-by assistance would be an effective intervention for Resident #1 to prevent falls.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Ashford Hall		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of an undated typed Incident Narrative revealed the MD name, address, and contact information in the heading. The Incident Narrative indicated Resident #1 resided at the SNF and was under the MD care. The Incident Narrative described Resident #1 was also a hospice patient . required assistance with ADLs, was non-ambulatory, incontinent of bowel and bladder, had extensive muscle wasting and deconditioning. The Incident Narrative indicated Due to his severe dementia . is unaware cannot walk, repeatedly stands from his wheelchair or bed, and immediately falls, which he has done multiple times. In the body of the Incident Narrative revealed [Resident #1] fell on [DATE], . sustained a superficial abrasion of the scalp in the forehead area. notified by nursing staff and ordered antibiotic to the abrasion. There was no evidence of any brain injury or neurological changes such as seizure, coma, mental status changes. The following day . developed a hematoma around the abrasion area, and determined at that time that a skull x-ray was indicated and ordered . The Incident Narrative closed with a statement of the MD's initial impression was confirmed when Resident #1 returned from the hospital without any finding other than a superficial abrasion of the scalp. The MD's typed name followed the closing, Thank you at the end of the Incident Narrative.</p> <p>Resident #2</p> <p>Record review of Resident #2's Quarterly MDS Assessment, dated 12/07/23, reflected a 76 y.o. female, who admitted to the facility on [DATE] from a long-term care facility. Resident #2 had a history and diagnoses of Dementia with behavioral disturbance; Unsteadiness on feet; Cognitive communication deficit; and Repeated falls. Resident #2 had a severe cognitive impairment per staff assessment because a BIMS interview was not conducted. Resident #2's functional status required one-person total assistance with ADLs, two staff assist with transfers, and independent with wheelchair for mobility (03/13/24).</p> <p>Record review on</p>		