

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 07/02/2024
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49733</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who was fed by enteral means received the appropriate treatment and services to prevent complications from enteral feeding for 1 of 2 residents (Resident #1) reviewed for enteral feeds.</p> <p>The facility failed to follow physician's order on 7/02/24 in accordance with the care plan for Resident #1's positioning during G-tube feeding.</p> <p>This failure could place residents with G-tubes at risk for aspiration and infection.</p> <p>The findings included:</p> <p>Review of Resident #1's Face Sheet, dated 7/2/24, reflected a [AGE] year-old male admitted to the facility on [DATE] with relevant diagnoses of Gastrostomy Malfunction (malfunction in the artificial external opening into the stomach such as blocked tubes), Chronic respiratory failure with hypoxia (below normal level of oxygen in the blood), Contracture of Right hand (a permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen), Chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), Shortness of breath, Nausea with vomiting, and Gastro-esophageal reflux disease without esophagitis (chronic upper gastrointestinal disease in which stomach content persistently and regularly flows up into the esophagus).</p> <p>Review of Resident #1's MDS assessment, dated 3/08/24, revealed a blank BIMS score. It further revealed the resident required Substantial/maximal assistance with rolling left and right and dependent with self-care.</p> <p>Review of Resident #1's Care Plan, accessed on 7/02/24, revealed the following:</p> <p>Resident was unable to use the push call light. Use of push pad call light.</p> <p>Resident needed feeding tube for nutritional support.</p> <p>Resident had dysphagia (difficulty swallowing) and at risk for choking/aspiration. ST recommendation that HOB is elevated during tube feedings.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident had cognitive/communicative impairment.</p> <p>Resident required assistance for activities of daily living due to Right hand and Right leg contracture, memory problems. Resident required limited 1 person assistance with bed mobility.</p> <p>Resident had impaired vision r/t a diagnosis of visual loss in both eyes. Keep call light in reach at all times.</p> <p>Resident at risk for impaired gas exchange and ineffective therapeutic management r/t chronic respiratory disease. Monitor for episodes of SOB and implement interventions as ordered.</p> <p>Observation on 7/02/24 at 10:31 AM revealed Resident #1 lying flat sideways in bed. The resident was lying sideways in the crease of the bed with legs bent towards the wall. The resident's nutritional feeding via G-tube was running. LVN B was observed in the hallway outside the room, facing Resident #1's room, passing out meds.</p> <p>In an interview on 7/02/24 at 10:32 AM, LVN B stated she was PRN and was not told of the correct positioning for Resident #1. She stated she believed the resident was not supposed to be in a flat position while the feeding was running. She stated the resident was at risk for aspiration if lying flat while nutrition was running. She stated she was just in Resident #1's room and he was not lying flat while she was in there.</p> <p>In an interview on 7/02/24 at 3:23 PM, LVN C stated the resident should be in an upright position while nutrition was running to help the flow of feeding by gravity and prevent aspiration. She stated residents with G-tubes should be checked on regularly to ensure the resident was in the correct position especially if residents were known to lower their beds or reposition themselves in bed.</p> <p>In an interview on 7/02/24 at 3:43 PM, the ADON stated the residents with G-tubes should be in an upright position if feeding is on. She stated aspiration was possible if resident was not upright and head was not elevated. She stated residents should never be lying flat when feeding is running. She stated Resident #1 moves around in bed and repositions himself. She stated the resident was checked on more frequently because of this. She stated she expected staff to assess and check on him often and pull him up to the HOB. She stated he could aspirate if he lays flat while nutrition is on.</p> <p>In an interview on 7/02/24 at 4:17 PM, the DON stated she expected G-tube residents be in an upright position while feeding to prevent aspiration. She stated Resident #1 repositioned himself a lot. She stated she expected the staff to check on him more often especially during feeding to avoid aspiration.</p> <p>Review of the facility's policy Maintaining Patency of a Feeding Tube (Flushing), revised November 2018, revealed . Review the resident's care plan and provide for any special needs of the resident. Position resident in semi-Fowler's (a supine position where a resident lies on their back with their head of bed elevated 15-45 degrees) or higher position.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49733</p> <p>Based on observation, interview, and record review, the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys, for 1 of 4 medication carts (Station 100) reviewed for pharmacy services.</p> <p>The facility failed to ensure LVN B ensured Medication Cart was locked when unattended in Station 100 hallway on 7/02/24 at 10:43 AM.</p> <p>This failure could cause accidental ingestion of medication by a resident not prescribed the medication and could cause access, loss, and diversion of medications.</p> <p>Findings included:</p> <p>Observation and interview with LVN B on 7/02/24 at 10:43 AM revealed LVN B was standing in front of her medication cart outside room [ROOM NUMBER] in Station one hallway. The medication cart was in the unlocked position. LVN B walked away from her cart and into Resident 1's room without locking her med cart. LVN B then walked back to the cart after 2 minutes and resumed working. LVN B stated she was distracted with the resident and forgot to lock the med cart before walking away. She refused to answer questions regarding the possible consequences of an unlocked med cart and stated the conversation was getting too deep.</p> <p>In an interview with the ADON on 7/02/24 at 3:43 PM, she stated she expected medications to be secured and locked in the medication cart. She stated med carts were to always be locked when not in use and when unattended. She stated residents or anyone walking by could access the medications left unsecured and cause harm.</p> <p>In an interview with the DON on 7/02/24 at 4:17 PM, she stated she expected staff to follow the facility's policy on securing medications and med carts. She stated she expected carts to be locked when unattended. She stated leaving medications unsecured placed residents at risk of an adverse reaction and harm if unprescribed medications were consumed by the residents.</p> <p>Record review of the facility's policy titled Medication Labeling and Storage, dated 2001, reflected: Policy Statement,</p> <p>The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys.</p> <p>Policy Interpretation and Implementation reflected:</p> <p>Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility policy titled Security of Medication Cart, revised April 2007, reflected: Policy Statement,</p> <p>The medication cart shall be secured during medication passes.</p> <p>Policy Interpretation and Implementation</p> <ol style="list-style-type: none"> 1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. 2. Medication carts must be securely locked at all times when out of the nurse's view. 3. When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room. 		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49733</p> <p>Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 5 residents (Resident #1) reviewed for infection control.</p> <p>The facility failed to ensure CNA A sanitized or washed her hands and changed gloves while providing incontinent care for Resident #1.</p> <p>This failure could place residents at risk for cross-contamination and infection.</p> <p>Findings included:</p> <p>Review of Resident #1's Face Sheet, dated 7/02/24, reflected a [AGE] year-old male admitted to the facility on [DATE] with relevant diagnoses of Contracture of Right hand and Right lower leg (a permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen), Need for assistance with personal care, Muscle wasting and atrophy (a progressive and degeneration or shrinkage of muscles or nerve tissues), muscle weakness, and lack of coordination.</p> <p>Review of Resident #1's MDS assessment, dated 3/08/24, revealed a blank BIMS score. It further revealed the resident was always incontinent of bowel and urine and dependent in toileting hygiene.</p> <p>Review of Resident #1's Care Plan, accessed on 7/02/24, revealed the following:</p> <p>Resident experienced bladder and bowel incontinence.</p> <p>Resident required assistance for activities of daily living due to Right hand and Right leg contracture, memory problems. Resident required total (dependent) assist of one staff with toileting and personal hygiene.</p> <p>Resident had impaired vision r/t a diagnosis of visual loss in both eyes.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 7/02/2024 at 10:31 AM, CNA A was in Resident #1's room to provide incontinent care. She donned double gloves without sanitizing/washing her hands. Incontinent care supplies were observed on the vanity about 4 feet from Resident #1's bed. CNA A opened the brief and pulled it down between Resident #1's thighs. CNA A looked around the room for wipes and a clean brief. CNA A walked to the vanity and picked up the wipes and a brief. CNA A removed a wipe from the plastic bag and wiped the resident's perineum and buttocks front to back and placed wipe in the trash. CNA A removed another wipe and wiped the buttocks again. CNA A repeated this process four times. CNA A rolled Resident #1 away from her, towards the wall, and removed the soiled brief and placed it in the trash. CNA A placed the clean brief under Resident #1 and walked to the vanity to retrieve cream for the resident. CNA A removed one set of gloves and placed in the trash. CNA A applied cream to Resident #1's buttock area, rolled him onto his back, and secured the brief. CNA A removed her gloves and washed her hands. CNA A did not change gloves or sanitize her hands while providing incontinent care to Resident #1.</p> <p>In an interview on 7/02/24 at 10:55 AM, CNA A stated she had been employed at the facility for 3 months and worked on the 6 am-2 pm shift. She stated she should have removed gloves before moving around the room and washed her hands between glove changes. She stated the facility provided hand sanitizer for the staff. She stated the facility does in-services on hand hygiene and infection control. She stated residents could be at risk of infections if staff did not wash or sanitize their hands between gloves changes.</p> <p>In an interview on 7/02/24 at 3:23 PM, LVN C stated infection control and hand hygiene should be practiced by staff when providing incontinent care. She stated it was important to get supplies ready before care was started to avoid cross-contamination. She stated dirty gloves were contaminated and staff should not touch the resident with contaminated gloves because it can cause infection. She stated staff should change gloves during incontinent care and hand hygiene performed before, during, and after care.</p> <p>In an interview on 7/02/24 at 3:43 PM, the ADON stated she expected aides to sanitize their hands before donning gloves and wash their hands with soap and water after incontinent care. She stated aides should wear gloves and change gloves when dirty. She stated failure to wash hands and change gloves could cause cross-contamination and possible infection.</p> <p>In an interview on 7/02/24 at 4:17 PM, the DON stated she expected aides to follow facility policy on hand washing and infection control. She stated hand hygiene and donning/doffing gloves were essential when providing incontinent care to avoid cross-contamination and infection.</p> <p>Review of the facility's policy Handwashing/Hand Hygiene, revised 2023, revealed the Policy Statement:</p> <p>This facility considers hand hygiene the primary means to prevent the spread of healthcare -associated infections.</p> <p>Policy Interpretation and Implementation revealed:</p> <p>1. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Indications for Hand Hygiene</p> <p>1. Hand hygiene is indicated:</p> <ul style="list-style-type: none"> a) immediately before touching a resident; b) before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); c) after contact with blood, body fluids, or contaminated surfaces; d) after touching a resident; e) after touching the resident's environment; f) before moving from work on a soiled body site to a clean body site on the same resident; and g) immediately after glove removal.