

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 09/24/2024
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 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507</p> <p>Based on interviews and record review, the facility failed to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility for 1 of 1 resident (Resident #1) reviewed for discharge requirements.</p> <p>The facility failed to ensure Resident #1 was readmitted from the hospital she was transferred to for treatment.</p> <p>The facility failed to provide Resident #1 a discharge notice.</p> <p>There was no documentation from the physician indicating the facility could not meet the Resident's needs.</p> <p>This failure could place residents at risk of unnecessary transfer or discharge causing their needs to go unmet.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 09/24/2024 revealed a [AGE] year-old female who was admitted to the facility on [DATE] and discharged on [DATE] at 12:36 PM. Resident #1's diagnoses included cerebral infarction, end stage renal disease, dependence on renal dialysis, ileostomy status, and mood disorder.</p> <p>Record review of Resident #1's Admission MDS, dated [DATE] revealed a BIMS score of 14 indicating intact cognition. Further review of the MDS revealed the resident's hearing was highly impaired and hearing aid/appliance was used.</p> <p>Record review of Resident #1's care plan, revised 05/19/2024, revealed I AM REQUIRED TO RECEIVES DIALYSIS THREE TIMES A WEEK, BUT I WILL REFUSE TO GO AND WILL BE AT RISK FOR INCREASED: SOB, CHEST PAINS, BLOOD PRESSURE, ITCHY SKIN, NAUSEA/VOMITING, AND INFECTED ACCESS SITE. I HAVE BEEN EDUCATED REGARDING THE RISK WHEN I REFUSE.</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 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's care plan, revised 06/12/2024, revealed On 4/30/24 I started to demonstrate aggressive behaviors. I CURSE AT STAFF WHEN IM UPSET, IN PAIN OR WANT MEDICAL ATTENTION. I AM COMBATIVE WITH STAFF, YELLS AT STAFF, CALL THE STAFF BITCHES, YELL ALL NIGHT, STAY ON THE CALL LIGHT EVEN AFTER THE STAFF ANSWERED THE CALL LIGHT, on 5/13/24 I spit on staff and used profanity. I REFUSE LAB WORK. Interventions included psych consult, report any behavior issues to MD, and staff to use individualized non medication interventions such as talking about horses or nature first before using medication for behaviors.</p> <p>Record review of Resident #1's progress notes, dated 07/27/2024 at 12:51 pm, written by ADON A revealed Report called to [Name] Hospital ER and spoke with a nurse, and she was informed that the resident has refused dialysis since 7/18/24, she refuses meds, yells and screams throughout the night and day, that bothers other residents, throws items at staff, refuses to be changed, threatens to throw colostomy on other people, and that she is a full code, she is also hard of hearing and suggest that she be admitted to the psych services at the hospital due to her behavior, she is going by 911 to the hospital.</p> <p>Record review of Resident #1's progress notes, dated 07/27/2024 at 12:59 PM, written by LVN B, reflected Resident taken out of facility by [Name] non-emergency transportation as they exited through the lobby the resident swiped the entry sign and it fell , she was heard yelling through the halls and outside as this nurse was on a call. The driver was asked if help was needed as he continued to transfer resident to vehicle. Resident continued to yell and shout. This nurse noticed the van had moved forward and paused and backed up several times. This nurse went out to the van and asked the driver if everything was alright. The driver stated that he was on the phone with his dispatch because the resident had threatened to take her colostomy bag off and throw it at him. He informed this nurse he could see the bag in his rearview mirror when he looked to check on resident and he was afraid to be hit with it. This nurse called the administrator to inform her of these events. Administrator told this nurse to call 911 and have resident picked up and taken to [hospital]. This was done. DON was informed of this as well and informed this nurse to update EMS of resident refusing dialysis and having psych issues.</p> <p>Record review of Resident #1's progress notes, dated 07/30/2024 at 10:43 AM, written by the ABOM, reflected Due to patient's non-compliance with care and behaviors, referrals have been sent to the following facilities for placement on 7.25.24:</p> <p>[Name]- Denied</p> <p>[Name]</p> <p>[Name]</p> <p>[Name]</p> <p>[Name] Denied</p> <p>[Name]</p> <p>[Name] Denied</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[Name]- Denied</p> <p>Patient was sent to [Name] Hospital on 7.27.24- Admissions Director explained in detail on patient's behaviors and non-compliance of care- Patient is unhappy here and will not allow staff to give care, patient screams with profanity at all staff. I gave the hospital the list of facilities referral was sent to.</p> <p>Record review of Resident #'s EHR did not indicate a discharge notice was given to Resident #1 and documentation by the physician did not indicate the facility could not meet Resident #1's needs.</p> <p>In an interview on 09/24/24 at 1:41 PM, the Social Worker stated Resident #1 refused dialysis, and declined psych services. She stated she explained to Resident #1 that she was actively dying when refusing dialysis and offered hospice, which Resident #1 declined. The Social Worker stated Resident #1 would not participate in PT and OT and refused everything the Social Worker offered her. She said she was on vacation when Resident #1 discharged and did not know why she was discharged to the hospital.</p> <p>In an interview on 09/24/24 at 2:32 pm, the Administrator stated they had gotten Resident #1 from another facility, and she came with a lot of behaviors. She said she broke 3 bedside tables and would throw dishes. She said she and the Social Worker met with Resident #1. The Administrator stated Resident #1 was sent to [Name] Hospital, who called her back and said nothing was wrong and would be sending Resident #1 back to the facility. The Administrator stated she told the hospital staff no, and Resident #1 needed some help. She said she has had to do that before so that hospitals would help with the patients. The Administrator stated Resident #1 was not suicidal but refused dialysis. She said she thought the root cause was mentally, as Resident #1 did not have dementia, and no UTI.</p> <p>Record review of the facility's policy titled, Transfer or Discharge, Facility- Initiated revised October 2022, reflected in part:</p> <p>1. Each resident will be permitted to remain in the facility, and not be transferred or discharged unless:</p> <p>a. the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility; .</p> <p>Notice of Transfer or Discharge (Emergent or Therapeutic Leave)</p> <p>1. When residents who are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers, NOT discharges, because the resident's return is generally expected.</p> <p>2. Residents who are sent emergently to an acute care setting, such as a hospital, are permitted to return to the facility. Residents who are sent to the acute care setting for routine treatment/planned procedures are also allowed to return to the facility.</p> <p>3. Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge:</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident;</p> <p>b. The resident's health improves sufficiently to allow a more immediate transfer or discharge;</p> <p>c. An immediate transfer or discharge is required by the resident's urgent medical needs; or</p> <p>d. A resident has not resided in the facility for 30 days .</p> <p>Notice of Discharge after Transfer</p> <p>1. If discharge is initiated by the facility after an emergency transfer to the hospital, the reason for discharge is based on the resident's status at the time the resident seeks return to the facility (not at the time the resident was transferred to acute care).</p> <p>2. If the facility does not permit a resident's return to the facility (i.e., initiates a discharge) based on inability to meet the resident's needs, the facility will notify the resident, and/or his or her representative in writing of the discharge, including notification of appeal rights.</p>		