STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455748	A. Building B. Wing	01/13/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42214 Based on observations, interviews, and record review the facility failed to protect the confidentiality of personal and medical records for one (RN E) of three staff observed for confidentiality of records. The facility failed to ensure RN E locked and closed the laptop during the medication pass exposing residents on the secured unit's personal information. This failure could affect residents by placing them at risk for loss of privacy and dignity. The findings included: Observation of the secured unit on 01/09/25 at 2:55 p.m., revealed the computer on the medication cart was unlocked and unattended which displayed residents' medications that needed to be passed. The computer was unattended near room [ROOM NUMBER] with the computer facing the hall. Two staff member and three residents passed the unattended computer. A male staff member later identified as RN E approached the surveyor from the opposite end of the hall stating the cart belonged to him. RN E locked the cart, stated he was assisting another nurse and returned to the other end of the hall. In an interview on 01/09/25 at 3:04 p.m., RN E stated he accidently left the computer unlocked when he left to assist another nurse and forgot to lock the computer. RN E stated leaving the computer unlocked, with residents' information opened, could give other residents, staff and visitors unauthorized access to residents medical information. In an interview on 01/09/25 at 3:15 p.m., The DON stated she had been the facility's DON for four days. The DON stated she was not aware of the unlocked and unattended computer on the medication cart of the secured unit. The DON stated computers should be locked when unattended. The DON stated this was the responsibility of any nursing staff member who was utilizing the computer to access resident information. The DON stated she would begin to Inservice staff on resident record confidentiality and would conduct random checks to ensure computers were secured when unattended. (continued on next page)

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

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/13/25 at 2:55 p.m. the ADMIN stated it was the expectation for all computers used to access residents medical information to be locked when unattended. The ADMIN stated all nursing staff were to ensure their computers were secured when not in use, as not doing so could lead to another resident or visitors having access to residents medical information. The ADMIN stated she would in-service nursing staff on resident record confidentiality and would check computers to ensure they were locked when not in use. Record review of the facility's policy entitled Protected Health Information (PHI), Safeguarding Electronic, revised in February of 2014, read in part: Policy Statement: Electronic protected health information (e-PHI) is safeguarded by administrative, technical and physical means to prevent unauthorized access to protected health information. Policy Interpretation and Implementation: 1. This facility ensures the confidentiality, integrity and availability of all e-PHI created, maintained, received, or transmitted by our information system. 2. Threats or hazards to the security of integrity of e-PHI will identified and mitigated as soon as possible. 3. All business associates are required to comply with security standards established by our business associate agreement relative to e-PHI .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42214 Based on interviews and record reviews the facility failed to ensure residents in the locked memory care unit were free from involuntary seclusion for one (Resident #1) of six residents reviewed for involuntary seclusion. The facility failed to obtain a physician order, documenting the clinical criteria met for placement in the secured/locked, prior to Resident #1's move to the secured unit on 11/21/24. This failure could place residents at risk for a decreased quality of life, a decline in physical functioning, and injury. Findings included: Record review of Resident #1's face sheet, printed on 01/13/24, revealed a [AGE] year-old female who admitted to the facility on [DATE]. Resident #1 had diagnoses to include Unspecified dementia with behavioral disturbance(a diagnosis of dementia where the exact type of dementia cannot be determined, but the individual also exhibits noticeable behavioral disturbances like agitation, aggression, wandering, or mood swings alongside cognitive decline), Other schizoaffective disorders(rare mental illness that combines schizophrenia and a mood disorder), and dementia in other diseases classified elsewhere, severe, with mood disturbance (a medical condition that involves severe mental decline, mood changes, and interference with daily life). Record review of Resident #1's MDS assessment, dated 12/13/24, revealed Resident #1 had BIMS score of 06, which indicated a severe cognitive impairment. Section E -Behavior, question E0900. Wandering - Presence & Frequency, indicated Resident #1 had not exhibited any wandering behaviors. Record review of Resident #1's quarterly MDS assessment, dated 11/15/24, Section E -Behavior, question E0900. Wandering - Presence & Frequency, indicated Resident #1 had not exhibited any wandering behaviors. Record review of Resident #1's care plan last revised on 01/03/25, revealed the following: -Problem Start Date: 11/22/2024 Category: Behavioral Symptoms I exhibit behaviors of trying to leave the facility wanting to go to work, catch the bus or look for my [family member][name]. Goal: I will wander safely within specified boundaries in my wheelchair. Approach: Approach Start Date: 01/11/2025 Assess I for placement in a specially designed therapeutic unit. Maintain a calm environment and approach to [Residnet#1] when she is wanting to leave to get [son]. Offer her one of her babies and remind her he is coming to see her as soon as he leaves work . Place [Residnet#1 in a secure environment .Remind [Resident #1] that she does not need to leave to catch the bus, [name] will be here soon .When [Resident #1] begins to wander, provide comfort measures for basic needs (e.g., pain, hunger, toileting, too hot/cold, etc.) (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Orders tab of Resident #1's electronic health record revealed an order, with a start date of 01/12/25, Resident requires secured unit due to unsafe wandering and exit seeking. The order was placed in the system by ADON C. Record review of the progress notes tab of Resident #1's electronic health record revealed a progress note written on 11/21/24 at 10:48 a.m. by SW B, which read [Resident #1] will move to room [number]. Resident and family are aware of the room change. Informed [RP] today and he would not like to be present. The room change will occur today 11/21/2024. Record review of the progress notes tab of Resident #1's electronic health record from 11/01/24 through 11/22/24 did not indicate Resident #1 exhibited wandering and/or exit seeking behaviors. Record review of the Events tab of Resident #1's electronic health record revealed two fall events, dated 11/20/24 and 11/21/24. No documentation of resident behaviors, including exit-seeking behaviors, was observed. An interview was attempted with Resident #1 on 01/09/25 at 3:00 p.m., the resident was observed in the common room of the secured unit, speaking to herself. The resident did not respond to the surveyor. In a telephone interview on 01/13/25 at 12:02 p.m., the PCP stated he would have to review Resident #1's records to see his involvement in her being moved to the facility's secured unit. While reviewing her electronic health record, the PCP stated the resident had significant dementia and confusion and several falls, which did not necessitate a secured unit. The PCP stated he saw Resident #1 was transferred to the unit but did not see any discussion of the reason. The PCP stated he did not recall giving a verbal or written order to place Resident #1 on the secured unit. The PCP stated he was not aware of any wandering or elopement attempts. The PCP stated he did not know Resident #1 was capable of eloping because she was not ambulatory and was unable to propel herself in her wheelchair. In an interview on 01/13/25 at 12:35 p.m., SW B stated Resident #1 was moved to the secured unit due to her risk level for elopement. The SW B stated when a resident is to be moved to the secured unit, it was his responsibility to notify the family or the move and to also speak with the roommate and their family and to document their involvement in the move. SW B stated he was notified by nursing staff when an order to move was obtained. SW B stated he could not recall who notified him of Resident #1's order. In an interview on 01/13/25 at 12:53 p.m., ADON C stated she had been the facility's ADON since 11/25/24 and prior to that she was the charge nurse for the secured unit. ADON C stated she placed the order in the system after reconciling physician orders not in the system. ADON C stated the order was a verbal order, she believed was given to the ADMIN. ADON C stated she was not aware that an order was not received prior to Resident #1's move to the secured unit. ADON C stated all residents who required to reside on the secured unit should have a need to reside on the unit, including a physician order. ADON C stated placing a resident on the secured unit without an order would be seclusion. ADON C stated she would continue to audit all resident on the secured units' charts to ensure all orders were in place. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 01/13/25 at 1:30 p.m., Resident #1's RP stated he received a call from a male facility staff member stating Resident #1 was being moved to the secured unit and a reason was not given. The RP stated he recalled receiving a call, but could not recall from who, stating Resident #1 had attempted to leave the facility, but he did not see how that was possible because Resident #1 could not walk or move too good in her wheelchair. Telephone interviews were attempted with RN A and RN D (who were nurses documented to have worked with Resident #1 on 11/20/24 and 11/21/24) on 01/13/25 from 1:40 p.m. to 1:45 p.m. but were unsuccessful. In an interview on 01/13/25 at 2:50 p.m., the ADMIN stated while on leave in November 2024, she received a call stating Resident #1 had opened the door near the Station 1 nurses' station and she was adamant about leaving to get her family memberafter recovering from a UTI. The ADMIN stated she was not aware a physician order was not obtained prior to Resident #1's move on 11/21/24. The ADMIN stated she could not recall who obtained the order, but Resident #1's PCP was aware of her move to the unit, as he had saw her while she was on the unit. The ADMIN stated it was the expectation for all residents being moved onto or from the unit, should have proper documentation and a physician order prior to being moved, as not having the order could seclude the resident. The ADMIN stated nursing staff were responsible for obtaining the physician order and document in the residents' chart, while the social worker was responsible for notifying the RP of care planning, notification of the move and coordination of the move. The ADMIN stated moves were discussed daily in the morning meetings and she planned to discuss moves more to ensure all items were in place. The ADMIN stated she would Inservice nursing staff on documentation and obtaining physician orders and the social worker on the process of moves. The ADMIN stated she would monitor all moves, as they are happening, to ensure all needed information was in the residents' chart when they are moved. Record review of the facility's policy entitled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised in April 2001, read in part: Policy statement: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the residents' symptoms .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42214 Based on observation, record review, and interviews the facility failed to assure that medications were stored in locked compartments under proper temperature controls and inaccessible to unauthorized staff and residents for one (Secured Unit Cart) of four medication carts reviewed for medication storage. The facility failed to ensure the Secured Unit medication cart was locked when left unattended by RN E. This failure could result in resident access and ingestion of medications leading to a risk for harm and possible drug diversion. Findings included: Observation of the secured unit on 01/09/25 at 2:55 p.m., revealed an unlocked and unattended medication cart near room [ROOM NUMBER]. A male staff member later identified as RN E approached the surveyor from the opposite end of the hall stating the cart belonged to him. RN E locked the cart, stated he was assisting another nurse and returned to the other end of the hall. In an interview on 01/09/25 at 3:04 p.m., RN E stated he accidently left the cart unlocked when he left to assist another nurse and forgot to lock the cart. RN E stated leaving the cart unlocked could give other residents, staff and visitors unauthorized access to medications. In an interview on 01/09/25 at 3:15 p.m., The DON stated she had been the facility's DON for four days. The DON stated she was not aware of the unlocked and unattended cart on the secured unit. The DON stated medication carts should be locked when unattended. The DON stated this was the responsibility of any nursing staff member who was assigned to the cart. The DON stated she would begin to Inservice staff on medication storage and cart security and would conduct random cart checks to ensure carts were secured when unattended. In an interview on 01/13/25 at 2:55 p.m. the ADMIN stated it was the expectation for all medication carts to be locked when unattended. The ADMIN stated all nurses and medication aides were to ensure their carts were secured when not in use, as not doing so could lead to another resident or visitors having access to the medications housed on the cart. The ADMIN stated she would in-service nursing staff on medication storage and would check carts to ensure they were secured at all times. Record review of the facility's policy entitled Security of Medication Cart, revised in April 2007, read in part: Policy Statement: The medication cart shall be secured during medication passes. Policy Interpretation and Implementation: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry . 3. When it is not possible to park the medication cart in the doorway, the cart should be parked in the hallway against the wall with doors and drawers facing the wall. The cart must be locked before the nurse enters the resident's room. 4. Medication carts must be securely locked at all times when out of the nurse's view. 5. When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room.