STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455823	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treemont Healthcare and Rehabilitation Center	5550 Harvest Hill Rd Dallas, TX 75230

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44021 Based on observations, interviews, and record review the facility failed to ensure resident has a right to a safe, clean, comfortable and homelike environment for 2 of 5 resident rooms, observed for environment. In resident rooms #1125 an #1207 tiles around the toilets were loose, missing pieces or otherwise separated. This failure could place residents at risk for living in an unsanitary and uncomfortable environment. Findings included: In an observation on 07/21/24 at 1:33 PM the bathroom floor in room [ROOM NUMBER] was observed to have two pieces of tile directly in front of the toilet that had approximately 2-inch by 2-inch pieces missing exposing the bare concrete below. In an observation on 07/22/24 at 1:29 PM the bathroom floor in room # 1207 was observed to have 5 pieces of tile bordering the toilet to have 1/4 inch gaps between the tiles exposing the concrete below. One tile directly to the right of the toilet had a large 1/2 inch crack directly down the middle of the tile exposing the bare concrete below. In an interview on 07/22/24 at 2:05 PM the Maintenance Supervisor revealed he knew about the tiles in the bathrooms and the crew that were fixing them had quit doing business months ago. He stated that the tiles looked bad and that the gaps and missing pieces could make it hard to sanitize the bathrooms. In an interview on 07/23/24 at 4:41 PM the DON revealed that a cracked or loose tile in the bathroom could pose a trip hazard if the tile slipped or if the edge of the tile was raised high enough off the floor. Review of a facility policy entitled Preventive Maintenance/Work-Order Request, dated 2003 revealed that 1. The facility will repair or replace damaged/broken equipment or building amenities as needed.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222 Based on observation, interview, and record review, the facility failed to ensure each resident received assistance devices to prevent accidents for 1 of 3 residents (Resident #75) reviewed for accidents. PTA G failed to apply a gait belt to Resident #75 prior to ambulating in the hallway. Resident #75 fell and suffered a skin tear to the left elbow and right forearm when PTA G was unable to secure Resident #75 to prevent the fall. This failure could place residents at risk for serious injury or harm, decline in health, and decreased quality of life. Findings included: Record review of Resident #75's face sheet dated 7/23/24 revealed Resident #75 was [AGE] years old with diagnoses of moderate protein-calorie malnutrition (malnourished) and urinary tract infection. Record review of Resident #75's care plan dated 7/10/24 with a revision date of 7/22/24 states Resident #75 was at risk for falls. Record review of Resident #75's MDS dated [DATE] revealed Resident #75 had a BIMS score of 14 (suggests cognition is intact), had a fall within the last month, and required partial to moderate assistance with ambulating. Observation on 7/22/24 at 3:37 p.m., Resident #75 was laying on the floor in the hallway with PTA G standing next to Resident #75. No gait belt was present on Resident #75 and a skin tear to the left elbow was visible. Interview on 7/22/24 at 3:37 p.m., PTA G stated a gait belt should have been placed on Resident #75. PTA G stated the importance of a gait belt was to secure the resident and have something to hold on to. PTA G stated she did not put a gait belt on Resident #75 because they were just going to get a few more steps in. Interview on 7/23/24 at 9:51 a.m., the Director of PT stated that all PT staff were expected to use a gait belt when working with residents and there were no excuses. Record review of Resident #75's progress notes written by LVN P dated 7/23/24 revealed Resident #75 fell and suffered a skin tear to the left elbow and right forearm. X-rays were ordered of left elbow, right forearm, and right hip. Record review of Resident #75's incident report dated 7/23/24 revealed Resident #75 did not have pain or a decline after the fall. Record review of the provider investigation report dated 7/22/24 revealed all x-rays were negative. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Moving a Resident with a date of 2003 states .h. Position a gait belt around the resident's waist and clasp it. Make sure it is tight enough that only a slight hand movement will guide the patient.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50445 Based on observation, interview, and record review, the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections for 1 (Resident #48) of 1 residents reviewed for catheter care. The facility failed to enssure Resident #48's catheter bag was not leaking urine. This failure affected one of five residents and could place residents with indwelling urinary catheters at risk of infection. Findings include: Record review of Resident #48's Admission Record, dated 07/22/2024 revealed he was a [AGE] year-old male originally admitted to the facility on [DATE] and most recently admitted [DATE] with a diagnosis of Obstructive and Reflux Uropathy (obstructed/blocked urinary flow). Record review of Resident #48's MDS , dated 05/28/2024, revealed a BIMS score of 14 and an active diagnosis of Diabetes Mellitus (a disease of inadequate control of blood glucose levels). His Functional Status assessment indicated he required two-person assistance for bed mobility, transfer, and toilet use, and setup help only for meals. Review of Resident #48's Physician Order written 05/27/2024 read to monitor Foley catheter every shift for leakage, blockage, sediment buildup, or low output. Review of Resident #48's Care Plan dated 03/07/2024 noted that Resident#48 had an indwelling catheter due to Obstructive and Reflux Uropathy (obstructed/blocked urinary flow). Observation on 07/21/2024 at 4:30 PM noted Resident #48 with an indwelling urinary catheter in a privacy bag hanging from the bed. The blue cloth privacy bag was partly saturated with urine and the room smelled of urine. The urine in the tubing was noted as cloudy with white sediment. The inside of the catheter bag was noted as stained. The bag was wet and could be seen leaking despite the clamp being noted as closed. The indwelling catheter bag was dated as changed two months ago. The resident could not provide information about his catheter care. In an interview on 07/21/20224 at 04:36 PM , CNA N stated she would tell the nurse if she noted a dirty or leaking Foley catheter so that they can change it. In a repeat observation of Resident #48 on 07/22/24 at 10:30 AM, the indwelling urinary catheter showed no changes. The Foley bag was in privacy bag hanging from bed. The blue cloth privacy bag was partly stained with urine. The urine in the tubing was noted as cloudy with white sediment. The inside of the Foley bag was noted as stained. The bag was wet and leaking despite the intact clamp, and the Foley bag was dated as changed two months ago. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/22/2024 at 10:46 AM, the ADON stated catheters were changed when they were dirty or leaking, and that if not changed, the risk to the patient is it could cause a UTI or other significant risk. In an interview on 7/22/2024 at 10:58 AM, CNA A stated if a Foley catheter was dirty or leaking, she would notify the charge nurse that it looks like it may need to be changed-it was time. In an interview on 07/22/2024 at 11:07 AM, LVN L stated catheters were changed according to the doctors' orders or prn. She reported if there was sediment or leaking, they would change it. She reported not changing a dirty or leaky bag could result in infection. In an interview on 07/22/2024 at 11:16 AM, LVN M reported catheters were changed according to the doctor's order. She stated she would change a catheter that was leaking, or if the bag was leaking, they could just change the bag. She reported that not changing a dirty or leaking bag could result in infection. Record Review on 07/22/24 at 12:55 of Progress Notes from 07/08/24 to 07/22/24 for Resident #48 noted there were no written notes regarding Resident #48's indwelling urinary catheter. Record review of the Facility Policies titled, Catheter Insertion UR and Catheter Care Nursing Policy and Procedure Manual 2003, revised February 13, 2007 noted that the policy stated that catheter care includes ensuring that there is no disconnection or leaking of urine from the system and to change the catheter and drainage system as needed unless ordered otherwise by the physician, and to maintain a sterile closed drainage system and if the closed system is broken, the system should be changed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50222 Based on observation, interview, and record review, the facility failed to ensure that medications were secure and inaccessible to unauthorized staff or residents for 3 of 4 medication carts reviewed for medication storage. The facility failed to ensure medication supplies were secured or attended by authorized staff when: RN H's medication cart for the Unit 2 was left unlocked and unattended. LVN J's medication cart for the Unit 3 was left unlocked and unattended. MA I's medication cart for the Unit 23 was left unlocked and unattended. This failure could result in resident access and ingestion of medications leading to possible drug diversion. The findings included: Observation and interview on 07/21/24 at 10:57 a.m., medication cart for Unit 2 was unlocked and unattended in the hallway. Door to room [ROOM NUMBER] opened and RN H exited the room, returning to the medication cart in the hallway. RN H stated medication carts should not be left unlocked because someone or a resident could take medications out of the cart. RN H stated medication carts should always be locked and was just going in a room to move a box when the cart was left unlocked. The following medications were on the cart: Gabapentin 300mg, Midodrine 10mg, Lasix 40mg, naproxen 500mg, and other medications. Observation and interview on 7/22/24 at 12:39 p.m., MA I entered room [ROOM NUMBER] to administer medications. Medication cart for Unit 23 was unlocked in the hallway next to room [ROOM NUMBER] and was not visible from inside room [ROOM NUMBER]. MA I stated the medication cart should always be locked because any resident could come and get medications out of the cart. The following medications were on the cart: famotidine 20mg, Depakote DR 250mg, Zyprexa 7.5mg, metoprolol 25mg, and other medications. Observation and interview on 7/22/24 at 4:42 p.m., LVN J entered room [ROOM NUMBER] and left the medication cart in the hallway unlocked. The medication cart was not in direct site of LVN J. LVN J then entered the bathroom in room [ROOM NUMBER] with the bathroom door closed and washed hands before returning to the medication cart. LVN J stated the medication cart should always be locked because anyone could take medications out of the cart. The following medications were on the cart: Cyproheptad 4mg, Insulin Lispro 100Unit/ML, Humalog 100Unit/ML, and other medications. Interview on 7/23/24 at 4:38 p.m., the DON stated the expectation was for medication carts to be locked at all times because it was just important for the cart to be locked at all times. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled, Recommended Medication Storage, did not address how medications should be secured. At the time of exit, no additional policy was provided. Additional policy was requested on 7/23/24 at 4:38 p.m. from the DON.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 44021 Based on observations, interviews, and record review the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 kitchen review for equipment safety. In the kitchen walk-in refrigerator and walk-in freezer, the fan cooling units were leaking. These failures could affect all residents that eat meals from the kitchen and pose a possible risk for cross-contamination. Findings included: In an observation on 07/22/24 at 10:20 AM in the kitchen walk-in refrigerator a large, five-gallon, food grade clear plexiglass bucket was observed to be half full of a water-like substance, liquid was observed dripping from a pipe connected to the fan-cooler unit above the bucket. The fan-cooler unit was observed to be making a clanking noise. A further observation in the kitchen walk-in freezer revealed that both fan-cooler units had ice build-up in the form of icicles that had dripped onto food boxes below building up 2-3 inches of ice on top of the food boxes. In an interview on 07/22/24 at 2:05 PM the ADM revealed that the fan-cooler units in the walk-in refrigerator had been fixed, she could not account how long the pipes may have been leaking. In an interview on 07/22/24 at 2:05 PM the Maintenance Supervisor revealed that he had fixed the leaking pipes in the walk-in refrigerator by blowing them out. He could not state how long the pipes may have been leaking but guessed he had probably been in the walk-in refrigerator area sometime last week. Review of a facility policy entitled Preventive Maintenance/Work-Order Request, dated 2003 revealed that 1. The facility will repair or replace damaged/broken equipment or building amenities as needed.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 44021 Based on observations, interviews, and record review the facility failed to maintain an effective pest control program so that the facility was free of pests for 1 of 1 kitchen areas, 2 of 5 (Resident #40 and Resident #66) resident rooms, and 2 of 3(First and Second Floor Dining Room) dining areas reviewed for environment . The facility failed to ensure the kitchen area was free of roaches before lunch service. The facility failed to ensure dining rooms were free of flies during the resident meal service. The facility failed to ensure resident rooms were free of flies. These failures could place residents at risk for insect borne illness, not having a home free of pests and a comfortable environment in which to live. Findings included: In an observation on 07/21/24 at 10:10 AM in Rm 1101 revealed three live gnats/small flies inside the room, alighting on tables and walls, there were no residents in the room at the time of the observation. In an observation and interview on 07/21/24 at 10:18 AM in the second-floor dining area, a few residents were gathered in the dining area of the second floor. Two gnats/black flies landed on Resident #25 in the dining area. Resident #25 stated that she does see those little black flies all the time and sometimes they land on her drink and plates. She also stated she normally eats in her room but wanted to come out that day. She stated that she sees gnats in her room also. In an interview on 07/21/24 at 12:26 PM Resident # 40 stated that she often sees little black gnats around the facility, especially in the dining area. She also stated that she has seen a roach in her room as well. In an observation and interview on 07/21/24 at 1:18 PM one small black fly was observed flying around Resident #99's face, another small black fly was observed to be on her bedside table next to the plate that she was eating off. She stated that she had seen gnats in her room all the time, but she has never seen a roach, she stated staff are aware. In an observation and interview on 07/22/24 at 10:26 AM a live roach was observed crawling down the stainless-steel wall going from the ventilation hood towards the 6-burner stove. Kitchen Manager was observed taking a cloth that was in her hand and killing the roach on the stainless-steel wall. She stated that pest control comes weekly, and she points out areas where she had seen roaches and pest control treats those areas. In an observation on 07/22/24 at 11:34 AM 8 residents and 3 staff members were observed in the first-floor dining area. A small black fly was noted to repeatedly land on the covered garbage can in the dining area. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/22/24 at 1:21 PM Residents #66 and #51 stated that they always see little black flies and the flies land on or around them all the time and both residents stated that the flies were very annoying. Resident #66 further revealed that she has seen a roach in her bathroom. Resident #66 stated that she has mentioned seeing bugs to the staff a few times. In an interview on 07/22/24 at 1:34 PM CNA A stated that she has seen black gnats around the facility. She stated that she was not sure where the Pest sighting log was but that if a resident complained of bugs or roaches she would tell the nurse or the maintenance manager. In an interview on 07/22/24 at 1:38 PM CNA B stated that she had never really heard of a pest sighting log, but that if she had seen a roach in the facility she would tell a nurse or the maintenance manager. She did state that she had seen lots of gnats in the facility and that the residents do complain about them. she stated that it could be bad if gnats land on residents or their food and it could possibly make residents sick or annoyed. She stated she would tell her nurse if she saw a roach in a resident's room. In an interview on 07/22/24 at 01:43 PM CNA C stated that she had seen black gnats in resident rooms and in the dining areas. she stated she was not sure where the pest sighting log was but would probably tell the maintenance supervisor about any bugs. she stated that she had not told the maintenance supervisor about any bugs lately but if she saw a roach, she would tell the nurse or the maintenance supervisor. In an interview on 07/22/24 at 2:28 PM the Maintenance Supervisor revealed that sometimes staff will come and tell him if there were insects in the building, he stated that the staff were to also put the sightings in the pest sighting log, which was located at the receptionist desk, and that would allow the pest control people to treat the areas identified in the logbook. He stated that having bugs in the facility could make residents feel bad and that he would not want to have roaches or flies in his home. In an interview on 07/23/24 at 4:41 PM the DON stated that roaches in the kitchen could offer a cross contamination issue and might not be safe for the residents. Record review of the pest sighting log revealed that on 7/22/24 a roach had been sighted in the kitchen, and the pest control company was found to visit the facility on a monthly basis or more often if requested. Policy review of a facility policy entitled Insect and Rodent Control dated 2012 revealed that The facility will maintain an effective pest control program to provide an insect and vermin free food service department.