STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455850	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hurst Plaza Nursing & Rehab	215 E Plaza Blvd Hurst, TX 76053

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care, reviewed for 1 (Resident #7) of 3 Residents reviewed for baseline care plan in that: The facility failed to update Resident #7's baseline care plan dated 09/15/24 which did not include his oxygen treatment, sleep apnea treatment, and need for assessments of O2 sats every shift. This deficient practice could result in newly admitted residents receiving improper care. The findings included: In an observation and interview with Resident #7 on 09/18/24 at 10:35 AM revealed his portable nasal canula tubing was in use but not dated. Resident #7 stated that he was admitted with his oxygen due to COPD and difficulty breathing. In an observation and interview with Resident #7 on 09/18/24 at 10:35 AM revealed the resident sitting in a power electric wheelchair moving to through the facility. No concerns observed. In an interview Resident #7 stated that he was admitted with his oxygen due to COPD and difficulty breathing. Record review of Resident #7's face sheet reflected he was a [AGE] year-old male with an initial admission on 05/31/24 and readmitted d on 09/15/24. MDS dated [DATE] reflected BIMS of 15 indicating he was cognitively intact, power wc, respiratory illness. Resident #7's DX included: Chronic Obstructive Pulmonary Disease COPD (lung disease), Anemia (blood disorder that decreased ability to carry oxygen to the lower extremities), Morbid obesity (severely overweight), Sleep Anemia, and Atrial Fibrillation (abnormal heartbeat rhythm.) Record review of Resident #7's MDS dated [DATE] reflected BIMS of 15 indicating he was cognitively intact DX of COPD, Sleep Apnea, and Morbid obesity addressed in MDS. respiratory illness. Oxygen treatments and Bi-PAP (Bi-level positive airway pressure machine that helps you breathe by delivering air through a mask) was addressed. Resident #7 requires assistant with toileting, hygiene care, transferring and bed mobility. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #7's baseline care plan dated 9/16/24 reflected he has a physical deficit functioning. Interventions he needed included assistance with dressing, toileting, bed mobility, keep call bell in reach. He was at risk of falls, interventions assess for pain, bed in low position, clear and monitor environment obstacles (tubes, cord), and encourage resident to wear footwear to prevent slipping. Resident #7's oxygen and sleep apnea treatments were not addressed. Record review of Resident #7's MD orders dated 7/8/24 reflected a prescription Oxygen: Oxygen at 3 L/HR every shift related To Chronic Obstructive Pulmonary Disease, Unspecified (J44.9). MD order dated 07/08/24 obtain vital signs: BP, HR, RR, SPO 2%, temp weekly. Enter in weights and vitals . one time a day every 7 day(s) for monitoring and safety. MD order dated 09/16/24 PRN Observe for s/s of resp illness-fever (>100 F), SOB, cough, sputum (mucus) production, sore throat, rhinorrhea (runny nose), chills (feeling cold), myalgias (muscle pain), fatigue, headache, new loss of taste or smell, & mental status changes. Document findings in PN. Notify MD of change in condition. Record review of Resident #7's progress note dated 09/15/24 by LVN T reflected the patient was on 1.5 liters of O2. Record review of Resident #7's progress note dated 09/15/24 by LVN C at 11:46 PM reflected Resident with Dx: COPD. DM Type II, Anemia/Sleep Apnea C-Pap in use at this time/ wears O2 at 2 L/P/M/NC continuous resident sleeping with C-Pap in place/ respirations even and unlabored. In an observation and interview with Resident #7 on 09/18/24 at 10:35 AM revealed the resident sitting in a power electric wheelchair moving to through the facility. No concerns observed. He stated that his medication did not arrive on time after his admission on 09/15/24. During an interview with the ADON on 09/19/2024 at 2:30 PM, she stated the baseline care plan includes and shows staff what needs to happen until a comprehensive [care plan] was provided. The nurse conducting admission assessment was responsible for documenting resident care needs, and the ADON and DON were responsible for ensuring the task was completed timely and correctly to address the resident needs. During an interview with the DON on 09/19/2024 at 2:40 PM the DON stated baseline care plan provides the resident care needs for the staff providing skilled care. The risk of not providing all needs could result in resident not receiving care and a decline in health. He stated that the ADON and DON were responsible for monitoring the admission care plan and resident needs. Record review of the facility policy, Care Plans - Baseline, was not provided.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on observation, interview, and record review the facility failed to ensure the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Residents 6) of 6 residents reviewed for comprehensive care plans. 1. The facility failed to revise Resident #6 to address recent falls on 09/09/24, 08/024/24, 08/29/24, and 08/09/24) 2. The facility failed to develop Resident #6 care plan to address oxygen use. 3. The facility staff failed to ensure Resident #6's hospitalization on [DATE] for a fall and injury (bruise) to the face. These failures could place residents at risk for possible adverse side effects, adverse consequences, and decreased quality of life and care. Findings included: In an observation with Resident #6 on 09/17/24 at 10:30 AM revealed Resident # 6 lying in bed on her back with NC in her nose with oxygen concentrator on. Resident # 6's bed was in a low position with a fall mat to the left of bed. Resident #6's eyes were closed and appeared to be asleep. In an attempted interview with Resident #6 on 09/17/24 at 10:30 AM and 09/18/24 at 9:30 AM revealed she was not interviewable due to confusion. Record Review of Resident #6's face sheet revealed a [AGE] year-old female with an admitted [DATE]. Resident #6 was admitted with diagnoses including Peripheral Vascular Disease (a vascular (vessel) disorder that causes abnormal narrowing of the parties) and vascular dementia (progressive loss of intellectual functions), cerebral atherosclerosis (hardening of your arteries, chronic kidney disease (failing kidney function). Record Review of Resident #6's MDS assessment dated [DATE] reflected a BIMS 5, oxygen was not addressed on the MDS, hospice addressed. Anti-anxiety and anti-psychotic, pain. Resident #6 requires assistance from staff for all care needs. There was no MDS found in resident's electronic records address her fall, decline in mental and physical functions on 09/19/24 during record review. Record Review of Resident #6's care plan dated 06/27/24 reflected she had a physical functioning deficit related to: Mobility impairment, Self-care impairment, risk of falls, related to a history of poor safety awareness, medication side effects, and attempts to ambulate without assistance/walker. Bed mobility assistance, call light in reach. Increased confusion. Hospice care with Vitas Hospice related to cerebral atherosclerosis. There were no revisions to address the fall on 09/09/24. Care plan did not address resident's fall on 08/24/24 and 09/09/24, O2 or hospitalization . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record Review of Resident #6's MD orders dated 07/17/24 reflected Monitor and record Temperature and 02 sats once daily, Monitor for the following: Fever [greater] than 99.0 F, Cough, Chest pain, Runny nose, SOB, Chills, Muscle pain, Headache, Loss of smell or taste, diarrhea and loss of appetite, or sore throat. If source of symptoms has not yet been determined or treatment implemented, follow up with MD for any positive findings Change Oxygen tubing weekly and PRN every night shifts every Sat for Oxygen use -dated 06/22/24 10:00 PM. Monitor for fatigue, weight gain, loss of consciousness Notify MD as needed .Admit to hospice dated 03/12/24. Record Review of Resident #6's physician orders revealed an order on 03/12/24 stating admit to nursing facility under Hospice for routine care with a diagnosis of hypertensive heart disease with heart failure. Record Review of Resident #6's Progress note 09/09/24 6:04 PM by LVN J reflected Nurses Note [HN] came and evaluated the resident no new orders at this time and continue with Neuro checks as protocol. Record review of progress note dated 08/29/24 IDT meeting by ADM reflected Bruise on 08/29/29 .Medical Records 'Event Being Reviewed: Bruise on 8/29/29. 'Root Cause Analysis for event: Resident has had a recent fall and noted with new behavior of combativeness with care. 'Interventions initiated and residents' response/compliance with Intervention: Facility to review medications due to change in combative 'PT/OT involvement if. applicable: NA 'New Interventions suggested following current IDT review: Facility to review medications due to change in combativeness. 'MD and family notification following new Interventions if applicable: MD and RP notified. Record review of Resident #6's progress notes by DON reflected Effective Date: 08/28/2024 08:47 AM Type: **Nurses Note Text: Observed resident standing at the front nurse's station. Her wheelchair was in the dining room approximately 50 feet away. As I assisted her back to her wheelchair, I asked her why. she was out of her chair. She stated, I am trying to get to my desk. placed her back in her W/C. and asked if she would like to go to her room. She stated no that she wanted to remain at the table with another resident. Record review of Resident #6's IDT note by ADM dated 08/27/24 reflected Unwitnessed fall on 08/24 .'Root Cause Analysis for event: Resident got up from bed and said she was trying to get her phone from her w/c. Resident does not have a Phone at the facility 'Interventions initiated and residents' response/compliance with Intervention: Family to bring resident's old phone from home for comfort. 'PT/OT involvement if applicable: Resident continues PT and OT services 'New Interventions suggested following current IDT review: Family to bring resident's old phone from home for comfort 'MD and family notification following new Interventions if applicable: MD and RP notified. Record review of hospital summary dated 08/09/24 at 9:15 PM reflected recent fall. Left sided facial bruising. No facial bony point tenderness .extremely lethargic (sluggish) which is her base line oriented times name only, vital signs are stable .Assessment plan: personal history of fall, facial trauma, precautions given. Low bed. High risk for falls. Due to dementia .closer observations. Hospice and DNR. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record Review of Resident #6's fall incident report by RN Y dated 09/9/2024 4:00 PM completed Event Initial Note Event Type: Unwitnessed fall Date of Event: 09/09/24 Time of event : 4:00 PM Detailed description of event (how, when, where, vitals, symptoms): Resident was found on the floor in her room by the nurses on duty, the resident was lying on the left side between the bed and the closet, and she has S/T (secondary to) on the left side of her left eye close to the eyelash and bump on the same side, resident is c/o of pain (headache)Tylenol given, head to toe assessment completed and the nurses and the CNA put the resident back on the bed, S/T was cleaned and dressing was placed. Patients' description of event: I was trying to go to the bathroom, and I lost balance and fell MD Notification (Date, Time, Method of communication): MD and HMD were notified on Hospice on 09/09/24 at 4:15 PM. Full Range of Motion Assessment findings: WNL. Responsible Party Notification: on 09/09/24 at 4:15 PM. Interventions (any interventions what we can do as staff to prevent this event from happening again): Head to Toe assessment completed. Educated the resident to use the call light for assistance. Bed in a low position. Floor mat paced. W/c on reach. MD, DON, Hospice, and family notified over the phone. The resident was lying on the left side when found. In in an interview with the MDS Coordinator on 09/19/24 at 11:00 AM who stated the while attending an IDT meeting last week, the team discussed that Resident #6 had fallen last week (she did not know the exact date.) MDS coordinator said that Resident #6 was ordered PRN oxygen last week by hospice. Interview on 09/19/24 at 2:15 PM with ADON who stated that the IDT members (ADM, ADON, DON, SW, MDS MD) were responsible for completing addressing resident declines, changes in care, interventions, and revisions. The ADON stated that the risk to resident's care plan not being updated would result in not receiving care and a decline in abilities. Interview on 09/19/24 at 2:25 PM with DON who stated that a revised care plan addressing recent falls, oxygen and hospitalization was needed for Resident #6. The IDT team met and discussed resident care needs after each fall. She provided no answer why the care plan was not updated, however she stated that the MDS coordinator was expected to follow the facility policy for significant changes in resident's conditions. He said failing to do so could result in resident not receiving services, care tracking for decline, and untimely accurate assessments. Interview on 09/19/24 at 2:33 PM with Administrator stated that Clinical staff and MDS consultant were expected to follow the facility policy for significant changes in resident's conditions. Administrator stated that he was aware that the ultimate responsibility falls on the facility to ensure a change of status MDS is completed. Record Review of facility policy titled Care Planning-Interdisciplinary team .Policy Statement The interdisciplinary team is responsible for the development of resident care plans. Policy Interpretation and Implementation 1. Resident care plans are developed according to the timeframes and criteria established by S483.21. 2. Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT). 3. The IDT includes but is not limited to: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	a. the resident's attending physician. b. a registered nurse with responsibility for the resident. c. a nursing assistant with responsibility for the resident. d. a member of the food and nutrition services staff. e. to the extent practicable, the resident and/or the resident's representative; and f. other staff as appropriate or necessary to meet the needs of the resident, or as requested by the resident. 4. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. 5. Care plan meetings are scheduled at the best time of the day for the resident and family when possible. 6. If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on observations, interviews, and record review the facility failed to ensure that residents requiring respiratory care were provided care, consistent with professional standards of practices for 5 of 7 residents reviewed for respiratory care (Residents #3, #4, #5, #6 and #7). 1. The facility staff failed to ensure Resident #3, #4, #6, and #7's nasal annular oxygen tubing was changed per the facility's policy and Physician orders on Sunday during the 10:00 PM to 6:00 PM shift and the following shifts by the nurse on 09/15/24, 09/17/24, and 09/18/24. 2. The facility staff failed to ensure Resident #3, #4, #5, #6, and #7's nasal annular oxygen tubing was dated per facility policy on 09/17/24 and 09/18/24. 3. The facility staff failed to ensure Resident #3, and #5's Sleep Apnea mask was bagged and dated when not in use per facility policy on 09/17/24 and 09/18/24. 4. The facility staff failed to ensure Resident #5's nebulizer mask was changed per the facility's policy. 5. The facility staff failed to ensure Resident #6's and Resident #7's portable NC oxygen tubing that was attached to their wheelchair was changed and dated per the facility's policy and Physician orders on 09/17/24 and 09/18/24. 6. RN P failed to ensure Resident #3's nasal annular that was attached to her portable oxygen and w/c was changed when found on the floor on 09/19/24. 7. The facility failed to ensure Resident #7's physician's order dated 07/08/24 was updated for continuous oxygen at the time of re-admission for respite on 09/15/24 nor addressed the tubing maintenance. These failures could place residents who require respiratory care at risk for respiratory infections, breathing in dust and allergens, decreased effectiveness of oxygen concentrators, and exacerbation of respiratory distress. Findings: Resident #3 In an observation of Resident #3's room on 09/17/24 at 12:30 PM revealed NC lying on the floor behind the oxygen concentrator and humidifier bottled dated 09/10/24. In an interview with Resident #3 on 09/17/24 at 12:30 PM she stated that the nurse checks her oxygen tubing daily, and she had some difficulty breathing at times. She does not remember when the last time her NC tubing was changed on her wheelchair or room concentrator. Observation of NC tubing revealed oxygen setting on 2 L and NC tubing was not dated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 9/18/243 at 1:00 PM revealed Resident #3's revealed the oxygen setting on 2 L and her NC tubing was not dated. In an observation of Resident # 3 on 9/19/24 at 9:45 AM revealed resident lying on bed with oxygen NC in her nose and dated with white tape 09/18/24. In an observation on 09/19/24 at 9:49 AM of Resident #3's wheelchair located in the hallway revealed the NC nostril prongs, and tubing lying on the ground unbagged and undated. This Surveyor walked to obtain assistance from a nurse and returned and discovered RN P. RN P accompanied this surveyor to Resident #3's wheelchair and observed a new piece of white tape dated 09/18/24, and the tubing was still on the ground. Record review of Resident #3's face sheet dated 09/19/24 revealed she was an [AGE] year-old female with an initial admitted [DATE] and readmission 08/07/24. DX included: Acute posthemorrhagic anemia (a low amount of hemoglobin in your red blood cells. Hemoglobin is a protein that helps red blood cells carry oxygen throughout your body.) Chronic Obstructive Pulmonary Disease (progressive lung disease), Asthma (inflammation of the airways to the lungs), Dependence on supplemental oxygen (Supplemental oxygen therapy helps people with COPD, and other breathing problems get enough oxygen to function and stay well.) Record review of Resident #3's QA MDS dated [DATE] with a BIMS score of 14 indicating she was cognitively intact. Section GG Functional abilities revealed she was independent with eating and required set up and clean up for hygiene. Substantial assistance for showers, toileting hygiene, dressing and personal hygiene. Section J reflected other conditions including SOB, with exertion and when lying flat. Section O reflected Resident #3 receives treatment for continuous oxygen therapy. Record review of Resident #3's care plan dated 6/25/24 reflected, Focus: Resident requires supplemental oxygen for respiratory status r/t Cardiac (heart) Diagnosis, COPD intervention to monitor for complications r/t oxygen use (ears, nose, dry mucous membranes) follow with MD and preventative measures as ordered Oxygen per nasal annular at 2 or more Liters/Min; Oxygen to be administered intermittently/Constantly to keep SA O2 > 90% ; Oxygen tubing changed per facility protocol. Focus: the resident has Alteration in Respiratory Status Due to Asthma, oxygen dependent. Interventions treatments Administer oxygen as needed per Physician order. Monitor oxygen saturations on room air and/or oxygen. Monitor oxygen flow rate and response .Elevate HOB to alleviate shortness of breath .Observe for changes in level of consciousness, restlessness, confusion . Record review of Resident #3's MD order dated 01/31/24 reflected an order document SP O2 and Temperature q shift for safety Change Oxygen tubing weekly and PRN every night shift every Sun for Oxygen uses. Record review of Resident #3's progress note dated 9/16/24 at 2:28 AM reflected a note from Skilled Status note Resident sleeping in bed with eyes closed. HOB up to 30%. 02 in place at 2 LPM/NC. Respirations even and unlabored. 02 Sat at 96%. No coughing or c/o dyspnea. No new s/s of bleeding/ no new bruising or bleeding. No reports of dark colored stools. No c/o palpations or chest discomfort. Remains Skilled. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's September 2024 TAR reflected that LVN C changed oxygen tubing. Additional TAR record review of nursing task to take and monitor vitals on the following dates 09/16/24, 09/17/24, and 09/18/24 were completed by RN P. In an interview with RN P on 09/18/24 at 9:55 AM, she said that she placed the white tape on NC tubing after the surveyor finished the observations. RN P stated that during her application of the tape she had not noticed the NC tubing on the floor. She stated that she would remove old tubing and change and date the [NAME] immediately. RN P stated that resident tubing should be changed weekly and as needed. She said tubing found undated or on the floor should be discarded immediately to prevent infection. Resident #4 In an observation and interview with Resident #4 on 09/17/24 at 10:40 AM revealed that his NC oxygen tubing not dated. NC in nose no complaints of breathing did not appear to be having any trouble breathing. Resident #4 said he does not remember when his oxygen tubing was last changed. Record review of Resident #4's face sheet dated 09/19/24 revealed he was a [AGE] year-old male admitted on [DATE]. DX included Acute Respiratory Failure, Diabetes Mellitus 2 (abnormal blood sugar levels). Record review of Resident #4's QA MDS dated [DATE], reflected he had a BIMS score of 03 indicating he was severely impaired cognitively. He required set up and clean up assistance for eating, he required partial staff assistance for oral hygiene, dependent on staff for toileting hygiene, dressing, bating and personal hygiene. Resident #4's oxygen was addressed in his MDS and DX of respiratory failure. Record review of Resident #4's Care plan dated 07/30/24 reflected Resident has alteration in Respiratory Status Due to Chronic Obstructive Pulmonary Disease, respiratory failure, pulmonary edema (excessive fluid accumulation in the tissue of the lungs interventions: Observe and document vital signs, specifically respiratory pattern, rate, rhythm, observe for changes .Observe for shortness of breath. Focus: Resident requires supplemental oxygen for respiratory status Hypoxemia (low level of oxygen in the blood.) Record review of Resident #4's MD orders dated 11/17/23 reflected Change Oxygen tubing weekly and PRN 10/21/23 Oxygen per nasal annular at 3 L/min to keep SA O2 > 90% No directions specified for order. 11/17/23 .Change O2 Tubing and Date every Sunday Night. Every Sunday dated 11/19/24 Anticoagulant medication - monitor for discolored urine, black tarry stools, sudden severe headache, N/V, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and / or v/s, sob, nose bleeds. Document n if monitored and none of the above observed. y if monitored and any of the above was observed, select chart Other/see nurses notes,' and enter findings in progress note. Monitor every shift for monitoring and safety, dated 11/17/2023 10:00 PM. Resident #5 In an observation of Resident #5 on 09/17/24 at 10:55 AM revealed resident nebulizer mask unbagged face down on a chair next to her bed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with Resident #5 on 09/17/24 at 10:55 AM revealed she does not remember if her oxygen mask was changed or if she had a bag. Resident was not interviewable based on her answers and inattentive to questions. In an observation of Resident #5 on 09/18/24 at 9:48 AM revealed resident nebulizer mask unbagged face down on top of her nightstand. Record review of Resident #5's face sheet revealed she was an [AGE] year-old female admitted on [DATE] DX Dementia (cognitive memory loss), Sleep apnea (sleep related breathing disorder). Record review of Resident #5's QA MDS type (none of the above) dated 07/15/24, reflected a BIMS score of 8 indicating moderate cognitive impairment. Section GG resident requires setup and clean up assistance supervision for oral hygiene and substantial/maximal assistance with toileting hygiene, showers, and dressing. Section O did not address oxygen therapy Bi-PAP or C-PAP. Record review of Resident #5's care plan dated 08/05/24 reflected Potential for sleep disturbance alteration r/t insomnia .intervention Medications as ordered if interventions not effective, reduce environmental distractions (e.g., close door to client's room; use night light rather than overhead light whenever possible; Record review of Resident #5's MD orders dated 09/12/24 ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3 ML 3 ml inhale orally every 6 hours as needed for SOB or Wheezing via nebulizer. Obtain vital signs BP, HR, RR, SP O2%, and temperature weekly .1 time every 7 days for safety and monitoring. Record review of Resident #5's September 2024 MAR reflected documentation of resident vitals being checked on 09/16/24. Record review of Resident #5's September 2024 MAR reflected documentation for MD order Albuterol treatment was documented as follows: 09/13/24 at 6:00 PM. 09/15/24 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. 09/16/24 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. 09/17/24 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. 09/18/24, 12:00 PM, and 6:00 PM. 09/19/24, 12:00 AM, 6:00 AM Resident #6 In an observation with Resident #6 on 09/17/24 at 10:30 AM she was lying in bed on her back with NC properly positioned in her nose with her eyes closed. Resident #6's oxygen NC tubing was not dated and touching the floor. (continued on next page)

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	455850	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hurst Plaza Nursing & Rehab	215 E Plaza Blvd Hurst, TX 76053

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an attempted interview with Resident #6 on 09/17/24 at 10:30 AM and 09/18/24 at 9:30 AM revealed she was not interviewable due to confusion. Record Review of Resident #6's face sheet revealed she was a [AGE] year-old female with an admitted [DATE]. DX included: Peripheral Vascular Disease (a vascular (vessel) disorder that causes abnormal narrowing of the parties) and vascular dementia (progressive loss of intellectual functions), cerebral atherosclerosis (hardening of your arteries, chronic kidney disease (failing kidney function). Record Review of Resident #6's QA MDS assessment MDS 07/12/24 BIMS 5, oxygen not addressed on MDS, hospice addressed. Anti-anxiety and anti-psychotic, pain. There was no Significant Change MDS found in resident's records. Resident #6 requires assistance from staff for all care needs. Record Review of Resident #6's care plan reflected she had a physical functioning deficit related to: Mobility impairment, Self-care impairment, risk of falls, related to a history of poor safety awareness, medication side effects, and attempts to ambulate without assistance/walker. Bed mobility assistance, call light in reach. Increased confusion. Hospice care with Vitas Hospice related to cerebral atherosclerosis There were no revisions to address the fall on 09/09/24, order for oxygen, and hospitalization . Record Review of Resident #6's MD orders dated 07/17/24 reflected Monitor and record Temperature and 02 sats once daily, Monitor for the following: Fever [greater] than 99.0 F, Cough, Chest pain, Runny nose, SOB, Chills, Muscle pain, Headache, Loss of smell or taste, diarrhea and loss of appetite, or sore throat. If source of symptoms has not yet been determined or treatment implemented, follow up with MD for any positive findings Change Oxygen tubing weekly and PRN every night shifts every Sat for Oxygen use -dated 06/22/24 10:00 PM. Monitor for fatigue, weight gain, loss of consciousness Notify MD as needed .Admit to hospice dated 03/12/24. Record Review of Resident #6's physician orders revealed an order on 03/12/24 stating admit to nursing facility under Hospice for routine care with a diagnosis of hypertensive heart disease with heart failure. Record Review of Resident #6's Progress note 09/09/24 6:04 PM by LVN J reflected Nurses Note [HN] came and evaluated the resident no new orders at this time and continue with Neuro checks as protocol. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #6's fall incident report by RN Y dated 09/9/2024 4:00 PM completed Event Initial Note Event Type: Unwitnessed fall Date of Event: 09/09/24 Time of event : 4:00 PM Detailed description of event (how, when, where, vitals, symptoms): Resident was found on the floor in her room by the nurses on duty, the resident was lying on the left side between the bed and the closet, and she has S/T on the left side of her left eye close to the eyelash and bump on the same side, resident is c/o of pain (headache)Tylenol given, head to toe assessment completed and the nurses and the CNA put the resident back on the bed, S/T was cleaned and dressing was placed. Patients' description of event: I was trying to go to the bathroom, and I lost balance and fell MD Notification (Date, Time, Method of communication): MD and HMD were notified on Hospice on 09/09/24 at 4:15 PM. Full Range of Motion Assessment findings: WNL. Responsible Party Notification: on 09/09/24 at 4:15 PM. Interventions (any interventions what we can do as staff to prevent this event from happening again): Head to Toe assessment completed. Educated the resident to use the call light for assistance. Bed in a low position. Floor mat paced. W/c on reach. MD, DON, Hospice, and family notified over the phone. The resident was lying on the left side when found. Resident #7 Record review of Resident #7's face sheet reflected he was a [AGE] year-old male with an initial admission on 05/31/24 and readmitted d on 09/15/24 for respite care. DX included: Chronic Obstructive Pulmonary Disease COPD (lung disease), Anemia (blood disorder that decreased ability to carry oxygen to the lower extremities), Morbid obesity (severely overweight), Sleep Anemia, and Atrial Fibrillation (abnormal heartbeat rhythm.) Record review of Resident #7's Admissions MDS dated [DATE] reflected BIMS of 15 indicating he was cognitively intact DX of COPD, Sleep Apnea, respiratory illness, and Morbid obesity was addressed in MDS. respiratory illness. Oxygen treatments and BiBap (B-ilevel positive airway pressure machine that helps you breathe by delivering air through a mask) was addressed. Resident #7 requires assistant with toileting, hygiene care, transferring and bed mobility. Record review of Resident #7's baseline care plan dated 09/16/24 reflected he has a physical deficit functioning. Interventions he needs assistance with dressing, toileting, bed mobility, keep call bell in reach. He was at risk of falls, interventions assess for pain, bed in low position, clear and monitor environment obstacles (tubes, cord), and encourage resident to wear footwear to prevent slipping. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's MD orders reflected an active written order dated 07/07/24 Admit to facility for Respite stay: 07/13/24 .order date 07/08/24 Head of bed elevated 30-45 degrees at all times every shift for SOB while lying flat . verbal order date 07/09/24 Document findings in PN. Notify MD of change in condition as needed .obtain vital signs: BP, HR, RR, SPO 2%, temperature weekly enter in weights and vitals. One time a day every 7 day(s) for monitoring and safety .written order date order date 09/15/24 by phone Monitor and record Temperature and 02 sats once daily, Monitor for the following: Fever >99.0, Cough, Chest pain, Runny nose, SOB, Chills, Muscle pain, Headache, Loss of smell or taste, Nausea or diarrhea and loss of appetite, or sore throat. If source of symptoms has not yet been determined or treatment Implemented, follow up with MD for any positive findings. one time a day . order date 09/16/24 Observe for sis of resp illness-fever (>100 F), SOB, Phone cough, sputum production. Sore throat, rhinorrhea, chills, myalgias, fatigue, headache, N/DN, new loss of taste or smell, & mental status changes. Resident #7's MD order dated 07/08/24 revealed that his oxygen order was not updated at the time of his admission on 09/15/24. Resident #7's oxygen orders did not address tubing maintenance and change for sanitary respiratory care. Record review of Resident #7's September 2024 TAR did not reflect nursing administration documentation of oxygen tubing. Record review of Resident #7's progress note dated 09/15/24 10:20 PM by LVN T reflected Patient admitted (per report) to facility under RESPITE care for one week. Patient is on 1.5 liters of O2 which was changed in 2030. Patient A/O X 3-4 Lungs clear. Patient experiences SOB r/t CHF. O2 continuous. HR reg. BS X 4 Edema (swelling fluid retention) X 2 lower extremities. Patient is on is type 1 DM and is on Lantus as ordered. Meds Cap minus 3. PEARL (Pupils (Are) Equal, Round, And Reactive (To) Light and Accommodation) verified with MD H and medications have been ordered and awaiting pharmacy delivery. Patient did not bring own meds and has been informed that meds will not be delivered until night run. Resident #7's admission PN documentation Patient is on 1.5 liters of O2 which was changed in 2030. Therefore, it was unclear in the Resident's documentation if orders were changed from 07/08/24 to 3 L. This may have been entered in error [2030] on 09/15/24. Record review of Resident #7's progress note dated 09/15/24 by LVN C at 11:43 PM reflected Resident with DX: COPD (an ongoing lung condition caused by damage to the lungs.) DM Type II (Type 2 diabetes is a chronic disease. It is characterized by high levels of sugar in the blood. Anemia (a condition in which the body does not have enough healthy red blood cells.) Sleep Apnea (A sleep disorder that is marked by pauses in breathing of 10 seconds or more during sleep and causes unrestful sleep.) A-Fib (an irregular and often very rapid heart rhythm) Hypertension (high blood pressure) Resident admitted at 1:15 PM today. Resident is here for seven days of Respite. Resident is AAOx3 (refers to the patient being alert and oriented to person, place and time) C-PAP (machine used to keep breathing airways open while you sleep) in use at this time/ wears O2 (oxygen) at 2 L (liter metric unit equal to volume of water) P (Pulse the rhythmic contraction and dilation of the arteries resulting from the beating of the heart), M (Meter a base unit of length)/NC (Nasal annular a device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help.) (Continuous. Abdomen obese with Bowel sounds active X (times) 4. Uses urinal (male urine collection container. At this time resident is sleeping with C-PAP (machine used to keep breathing airways open while you sleep) in place/ respirations even and unlabored. Call Bell/urinal/ and fluids within easy reach. Resident oriented to surroundings. Encouraged to have someone present during transfers. Stable. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In in an interview with RN P 09/19 /24 at 9:45 AM admitted to placing the white tape on Resident #3's oxygen tubing that was still on the floor. She said she would change and date. Dating prevents overuse. In in an interview with the MDS Coordinator on 09/19/24 at 11:00 AM she stated the MDS significant change or decline in 2 areas of care treatment and changes in services to the patient. She would be notified by the IDT team in the weekly morning meeting. She said in the meeting discussion, Resident #6 had not had a change in her medical needs. She stated that Resident #6 had fallen last week (she did not know the exact date.) MDS coordinator said that Resident #6 was ordered PRN oxygen last week. She said this did not warrant a significant change in MDS assessment. She did not answer the risk to residents. MDS consultant stated she was not directed to complete a significant change for Resident #6 in the IDT meeting. In an interview on 09/19/24 at 02:15 PM with ADON she stated that she expects the 10:00 PM to 6:00 AM to change and date tubing weekly on Sunday's, and the 6:00 AM to 2:00 PM staff were responsible for auditing tubing for dates during their care rounds and checking vitals. She stated it was the ADON and DON responsibility to monitor nursing task. The ADON said the risk of not dating resident tubing can result in respiratory infections and illnesses. In interview on 09/19/24 at 2:25 PM, the DON stated the charge nurses were responsible for changing the oxygen tubing and humidifier bottles weekly. He stated by not doing so could cause oxygen delivery issues or infections. The DON said he and the ADON was responsible for ensuring processes are in place. During an interview on 09/19/24 at 2:335 PM, the Administrator said nursing was responsible for, changing the tubing and bottles every Sunday, and as needed. He said the DON was to oversee that the nursing staff were following the respiratory care policy and expected respiratory equipment to be cleaned and changed weekly. He said the residents could be at risk for infections. Record Review of facility in-serviced dated 09/18/24 by DON reflected Topics: 02 and Nebulizer Infection Control of Tubing and Masks for oxygen and nebulizer's MUST be changed q 7 days and labeled with the date that the new tubing/mask is placed in use .02 concentrators and their filters MUST be sanitized q 7 days Nebulizer's MUST be sanitized q 7 days. Humidifier containers MUST be replaced q 7 days and PRN Nasal annular's, masks, nebulizer administration sets Must be bagged and labeled when not being used. ALL nurses, no matter which shift you are working, MUST pay attention to these points whenever you enter a resident's room, and MUST correct any issues as you find them. Please read the attached policy and print and sign your name on last page acknowledging understanding what is expected of you regarding this matter. The facility's ADM did not provide the policy for respiratory care was requested on 09/18/24 and 09/19/24 and was not provided at the time of exit.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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. 44970 Based on observation, interview and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological's, to meet the needs of each resident for 1 of 3 medication aides on the west hall. The facility failed on 09/19/2024 when MA O's medication cart was left unattended and unlocked as she walked away to administer medications to another resident. This failure could place residents at risk for misappropriation of property and could place residents at risk for accidents, hazards, and not receiving therapeutic effects. Findings included: Observation on 09/19/24 10:25 AM on the west hall Medication aide cart with MA O revealed the cart in front of a patient's door, lock out indicating it was not secured. She was observed in the room with her back to the cart for approximately 1.50 minutes. There was a total of 2 residents in their wheelchairs propelling by the cart. Interview on 09/19/24 10:30 AM, MA O stated it was her responsibility lock the cart when walking away to prevent staff, visitors, and residents from accessing prescription medication. She said that something bad could happen if the resident accessed cart and took medications. She stated she locks the cart when walking away, however if she has the cart parked in front of the resident room it was in view for her to observed. She said she medication administration training requires the medication cart to be locked upon walking way for resident safety. Interview on 09/19/24 at 2:30 PM with the ADON stated it was all medication administration certified staff's responsibility to lock the cart before walking away. She said the ADON and DON have been monitoring the carts, and this MA was a long-term staff that knew the protocol. Failing to secure the medication cart could result in residents' medication being missed, stolen, or resident accessing cart and having an adverse reaction. She stated that the MA would return to medication administration training and complete regular monitoring and auditing to ensure the safety of the residents. Interview on 09/19/24 02:40 PM, the DON stated it was the ADON and DON's responsibility audit monitor and ensure medication protocol was followed by all certified medication staff. He stated by leaving medication carts unlocked, the cart could be accessed, and medication taken by visitors and other residents passing by. Interview on 09/19/24 02:50 PM ADM stated medication carts should be secured at all times when not attended to prevent medication theft and resident access. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of facility's Policy dated 11/2020 and titled reflected Storage of Medications Policy heading the facility stores all drugs and biological's in a safe, secure, and orderly manner. Policy Interpretation and Implementation. Drugs and biological's used in the facility are stored in locked compartments Only persons authorized to prepare and administer medications have access to locked medications. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biological's are locked when not in use. Unlocked medication carts are not left unattended.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with professional standards of practice and the comprehensive care plan for 1 of 8 residents (Resident #7) reviewed for quality of care. The facility failed to document Resident #7 diagnosis of COPD and oxygen orders on the care program. This failure could place residents at a risk of being receiving incorrect treatment. Findings included: Record review of Resident #7's face sheet reflected he was a [AGE] year-old male with an initial admission on 05/31/24 and readmission for respite dated on 09/15/24. Record review of Resident #7's MDS dated [DATE] reflected BIMS of 15 indicating he was cognitively intact. Resident #7 requires staff assistant with toileting, hygiene care, transferring and bed mobility. Record review of Resident #7's care plan dated 09/16/24 reflected he has a physical deficit functioning. Interventions he needs assistance with dressing, toileting, bed mobility, keep call bell in reach. He was at risk of falls, interventions assess for pain, bed in low position, clear and monitor environment obstacles (tubes, cord), and encourage resident to wear footwear to prevent slipping. Record review of Resident #7's MD orders dated 07/8/24 reflected a prescription Oxygen: Oxygen at 3 L/HR (liters per hour) every shift related To Chronic Obstructive Pulmonary Disease, Unspecified (J44.9). MD order dated 07/08/24 obtain vital signs: BP, HR., RR, SPO (see acronyms) 2%, temperature weekly. Enter in weights and vitals .one time a day every 7 day(s) for monitoring and safety. MD order dated 09/16/24 PRN Observe for s/s of resp illness-fever (>100 F), SOB, cough, sputum (mucus) production, sore throat, rhinorrhea (runny nose), chills (feeling cold), myalgias (muscle pain), fatigue, headache, new loss of taste or smell, & mental status changes. Document findings in PN. Notify MD of change in condition. Record review of Resident #7's September 2024 TAR did not reflect nursing administration documentation of oxygen tubing. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #7's progress note dated 09/15/24 10:20 PM by LVN T reflected Note Text: Patient admitted (per report) to facility under RESPITE care for one week. Patient is on 1.5 liters of O2 which was changed in 2030. Patient A/O X 3-4 Lungs clear. Patient experiences SOB r/t CHF. O2 continuous. HR reg. BS X 4 Edema (swelling fluid retention) X 2 lower extremities. Patient is on is type 1 DM and is on Lantus as ordered. Meds Cap minus 3. PEARL (Pupils (Are) Equal, Round, And Reactive (To) Light and Accommodation) verified with MD H and medications have been ordered and awaiting pharmacy delivery. Patient did not bring own meds and has been informed that meds will not be delivered until night run. Record review of Resident #7's progress note dated 09/15/24 by LVN C at 11:43 PM reflected Resident with Dx: COPD (.an ongoing lung condition caused by damage to the lungs.) DM Type II (Type 2 diabetes is a chronic disease. It is characterized by high levels of sugar in the blood. Anemia (a condition in which the body does not have enough healthy red blood cells.) Sleep Apnea (A sleep disorder that is marked by pauses in breathing of 10 seconds or more during sleep and causes unrestful sleep.) A-Fib (an irregular and often very rapid heart rhythm) Hypertension (high blood pressure) Resident admitted at 1:15 PM today. Resident is here for seven days of Respite. Resident is AAOx3 (refers to the patient being alert and oriented to person, place and time) C-PAP (machine used to keep breathing airways open while you sleep) in use at this time/ wears O2 (oxygen) at 2 L (liter metric unit equal to volume of water) P (Pulse the rhythmic contraction and dilation of the arteries resulting from the beating of the heart), M (Meter a base unit of length)/NC (Nasal cannula a device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help.) (Continuous. Abdomen obese with Bowel sounds active X (times) 4. Uses urinal (male urine collection container. At this time resident is sleeping with C-PAP (machine used to keep breathing airways open while you sleep) in place/ respirations even and unlabored. Call Bell/urinal/ and fluids within easy reach. Resident oriented to surroundings. Encouraged to have someone present during transfers. Stable. Interview on 09/19/24 at 2:33 PM, the ADM who stated that he expected the nursing staff to follow admissions policy and protocol for new admission physician orders. He said the risk to residents could result in services and orders not being followed. Interview on 09/19/24 at 2:25 PM, the DON who stated the admitting nurse was responsible for entering all orders for the attending physician to review orders and change them as needed. The DON stated there should be no reason for the admitting nurse omitting the O2 oxygen orders. The DON stated he did not know at the time which nurse completed the admitting The DON stated that it was his expectation for nursing staff to consult with MD admission orders and submit for resident care. He said the risk to residents could result in services and orders not being followed. Review of the facility's policy dated March 2017 titled Admissions admissions - From the Community Policy Statement Residents from the community who's medical and nursing care needs can be adequately met may be admitted to this facility. 1. Policy Interpretation and Implementation resident may be admitted directly from the community to the facility upon the written order of the resident's primary healthcare provider. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	2. Prior to, or at the time of admission, a resident admitted from the community to the facility will have the following information available to assure that the immediate care needs of the resident can be met: admitting diagnosis and prognosis; Current medical status; Physician orders for immediate care; and Others as necessary or appropriate. A physical examination will be made within forty-eight (48) hours of the resident's admission unless a physical examination was completed not more than five (5) days prior to the resident's admission. 3. A copy of the physical examination must be provided to the facility and filed in the resident's admission record. 4 .A summary of the resident's prior treatment(s) and his or her rehabilitative potential (long-term and short-term) will be provided to the facility within forty-eight (48) hours of the resident's admission.