STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455996	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Renaissance at Kessler Park	2428 Bahama Dr Dallas, TX 75211

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44894 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury for 1 of 63 resident (Resident #1) reviewed for neglect, in that: The facility failed to report the allegation of neglect r/t falls for Resident #1 to the State Agency within required reporting timeframes. This failure placed residents at risk of ongoing neglect. Findings included: Record review of Resident #1's face sheet dated 07/09/2024 revealed a [AGE] year-old female admitted to the facility on 04/25/2001 and readmitted on [DATE] with a diagnoses of Multiple Fractures of Ribs, Bilateral (affecting both Rt. And Lt. sides of ribs), initial Encounter for Closed Fracture (occurs when multiple ribs are broken in multiple places, separating a segment which is free-floating and moves independently), Dementia in other Diseases Classified elsewhere, moderate without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety (a person is presenting signs and symptoms of dementia and lack symptoms of behavioral disturbances). Record review of Resident #1's MDS (Minimum Data Sheet) dated 06/26/2024 revealed Resident #1 BIMS (Brief Interview for Mental Status) score was noted to be 06/15 indicating severe cognitive impairment. Resident #1 required modified to total assistance making decisions regarding tasks and providing daily care. Resident requires minimal to maximum to prevent falls. Interventions in place to prevent falls noted on Care Plan noted as adaptive equipment available to resident, modified seating, (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Place frequently used items within reach, provide Reacher for resident, bed in low position, and appropriate footwear while ambulating. Medical records dated 06/05/2024, indicated Resident #1 had two unwitnessed falls. The first fall dated 06/04/2024, resident was found in the bathroom on the floor by the MA. The resident received a skin tear to the back of her right wrist and the back of her left wrist had a reddish discoloration. X-ray taken on 06/04/2024 reflected healed ORIFs distal radius and ulna multiple fractures of ribs and clavicle (a surgical procedure to treat a fractured ulna and radius (bones in forearm), multiple fractures of the ribs and clavicle (combination of injuries may result in decreased stability of the chest wall, making these patients prone to respiratory complications and prolonged hospitalization s), Left hand Arthritis (swelling in one or more joints causing pain and stiffness), Right hand NAD (hand numbness can be caused by damage, irritation, or compression of nerve or a branch of a nerve in arm or wrist). Medical records dated 06/15/2024, indicated resident had second unwitnessed fall on 06/14/2024. On 06/15/2024, CNA reported to RN Resident #1 had pain and swelling to her left hand. Resident #1 reported to the CNA that she had a fall the day before after breakfast and she got herself up. The NP ordered an x-ray to the left wrist and hand. On 06/15/2024 at 6:00 pm, Resident #1 became drowsy while in the dining room. Resident #1 was taken back to her room and placed in bed where she began to have a seizure. Resident #1 was sent to hospital and was admitted . The RN informed the ER nurse about the pending x-ray of Resident #1's left wrist and hand. Medical record dated 06/18/2024, indicated Resident #1 readmitted to facility. Skin assessed, noted greyish bruising to left hand, no swelling but discomfort with movement. Bruised area on left elbow area from hospital IVs sites. Medical record dated 06/19/2024, Day 2 readmission indicated Resident #1's left wrist and forearm bruised from post fall. Medical record dated 06/20/2024, Day 3 readmission indicated Resident #1's left wrist and forearm continued to be bruised from post fall. No swelling noted. Pain to left wrist area, medicated for pain with Tramadol 50mg, med was effective. Medical record dated 06/23/2024, indicated Resident #1 continued to be monitored r/t falls. Resident up in w/c at nurse station most of shift, medicated x1 for left wrist/forearm pain. Left hand discolored. Medical record dated 07/01/2024, indicated Resident #1 received pain pill at this time per complaining of left-hand pain. X-ray ordered of left ulna. X-ray report back with impression, acute undisplaced fracture of the distal metaphysis of the left radius in good position, no dislocation. The MD was notified and gave order to send patient to the ER. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/09/2024 at 3:45 p.m. interview with the Administrator, revealed that she is responsible for sending the reports to the CII provider number. The Administrator revealed that her expectations would be to notify the Provider Investigation Report within 2 hours or 24 hours and complete the 5-day Provider Investigation Report. The Administrator revealed that was not completed because Resident #1 was sent out to the hospital before the x-ray could be completed. The Administrator revealed that the facility administration must report all incidents with injuries to the CII provider immediately after the incident occurred. Asked Administrator if Resident #1's falls that occurred on 06/4/2024 and 06/14/2024 reported to the State? The Administrator revealed that the falls were not reported because they did not know there were any injuries the time of the falls. The fall that occurred on 06/04/2024, the results were received on 06/05/2024 resulting left wrist x ray: healed ORIFs distal radius and ulna. Clavicle: Multiple fractures of the ribs and clavicle. Hand: left hand arthritis. The fall was not reported to the State. The unwitnessed fall that occurred on 06/14/2024, an x-ray was ordered, but resident was sent to the hospital before the x-ray could be completed. Resident #1 was complaining of left hand, wrist, pain and swelling. On 06/15/2024, Resident #1 noted to have seizure activity while in dining room. Was transported to hospital. Resident return to facility on 06/18/2024. Hospital did not complete an X-ray of resident's right wrist. On July 1, 2024, resident continued to complain of pain in left wrist. Resident continued to have pain in left wrist from 06/14/2024 - 07/01/2024. Asked Administrator if incident was reported to SA. Administrator revealed no it was not reported to SA because Resident #1 was sent to hospital before an x-ray was completed. Record review of the facility's Abuse, Neglect, and Exploitation policy dated 10/24/2022 revealed in part: the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. .Reporting all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegations do not involve abuse and do not result in serious bodily injury.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44894 Based on interview and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of two residents reviewed for quality of care. The facility failed to call physician for an x-ray order of Resident #1's left wrist and hand in a timely manner, which resulted in delayed treatment for a period of 7 days without treatment. On 06/15/2024, approximately 7:45 AM CNA B reported to RN A, pain and swelling in Resident # 1's left hand. Left hand noted swollen. Resident # 1 revealed difficult to move at wrist, there was swelling and slight reddish bruising. Resident stated she fell on [DATE] after breakfast. Resident #1 was able to get herself up. Resident #1 assessed by RN A, DON notified. X-ray order was received from the APN to x-ray left wrist and hand on 06/15/2024 approximately at 7:45 AM. On 06/15/2024 at approximately 6:00 PM, Resident #1 had seizure activity and the resident was transfer to hospital for further evaluation. On 06/18/2024 at approximately 1:50 PM, Resident #1 returned to the facility. The resident complained of pain in the left wrist and hand on 06/19/24, 06/20/24, 06/23/24, and 07/01/24. On 7/01/24 an x-ray was ordered due to the pain; results indicated the resident had an acute displaced fracture of the distal metaphysis of the left radius. The noncompliance was identified as PNC. The IJ began on 06/18/24 and ended on 07/01/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of a delay in medical evaluation, treatment and decrease in quality of care by not ordering x-ray in a timely manner [14 days later] to protect resident from further pain. Findings included: Review of Resident #1's face sheet dated 07/09/2024 revealed the resident was a [AGE] year-old-female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1's diagnosis included Multiple Fractures of Ribs, Bilateral, Initial Encounter for Closed Fracture (Broken or cracked ribs three or more in two places and did not break through skin); Disorder of Bone Density and Structure, Unspecified (Bone mass and mineral density decreases, causing disorder in bone Density and structure of bone changes); Dementia in Other Diseases Elsewhere Classified Moderate, without Behavioral Disturbances, Psychotic Disturbances, Mood Disturbances, and Anxiety (Caused by disorders of the brain: Memory Loss, Problem solving, emotional control, impaired thinking abilities that interfere with daily functioning). Review of Resident #1's quarterly MDS Assessment, dated 06/26/2024, revealed Resident #1 was usually understood by others and was able to understand others; the resident's cognitive assessment/BIMS Score was 06/15 indicating moderate cognitive impairment. Transferring between bed, chair, wheelchair, and standing position required supervision or touching with one person assist. Locomotion in the room required supervision with one-person assist. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's care plan, undated, revealed Resident #1 was at risk for the following care areas: *Musculoskeletal status r/t diagnosis of osteopenia, and history of fractures. *ADL self-care performance deficit and at risk for not having her needs met in a timely manner. Goal: She will maintain a sense of dignity by being clean, dry, odor free and well-groomed through the next review. Intervention: Toilet use: requires x1 staff to assist, Transfer requires x1 staff assist with transferring, Bathing requires extensive assistance x1. Resident #1 at risk for falls related to unsteady balance and antidepressant use. Goal: will be free of falls by next review. Intervention: Call light within reach, encourage to call for assistance, resident has a history of unreported falls and getting self-up without notifying staff of the event; 06/14/2024 Fall; educated resident/family/caregivers about safety reminders and what to do if a fall occurs; fall mat to be beside the bed, keep needed items, water, etc. in reach, bed in lowest position, provide activities that promote exercise and strength building where possible. Review of Resident #1's progress notes dated 06/15/2024 at 7:45 AM, documented by RN A reflected: CNA B reported to writer pain and swelling to residents left hand. Left hand noted swollen with slight reddish bruising. Resident states difficult to move at wrist. Capillary refill < 3sec. Sensation intact. (Nurse pressed skin down on left hand and blood refilled within 3 seconds. Resident had feeling in her hand). Resident stated she fell yesterday after breakfast, and she got herself up. No other injuries noted. Neuros stable [Physician] and DON notified. On 06/15/2024 at approximately 7:45 AM, orders received from APN to x-ray left hand and wrist. Phoned family member. Message left. Resident medicated with PRN pain med. Continue to monitor. Resident at nurses' station at present. Alarm in place. X-ray ordered. Pain scaled noted on MARS for 06/15/2024 were documented as 0 on a scale of 0-10. Review of Resident #1's physician orders, dated 06/04/24, revealed a STAT x-ray to right clavical. Humerus, elbow, forearm, wrist and right hand and left hand was ordered but the x-ray start date is blank, indicating it was not completed. Review of Resident #1's physician orders, dated 06/15/24, revealed, an x-ray was ordered for the left wristand hand related to pain and swelling. Review of Nurse MAR documented by RN A reflected on 06/15/2024, 8:00AM, Ibuprofen Oral tablet 600 mg. Give 1 tablet by mouth every 6 hours as needed for moderate pain was administered to Resident #1. Resident #1's pain level was document as a 3 on a scale of 0 - 10. Review of Resident #1's progress note dated 06/15/2024 at 12:00 PM documented by RN A reflected: Resident up in w/c watching TV in lobby. No c/o pain or discomfort. States, No, only if I bend it. No signs of pain at this time. Hand supported/elevated. Neuros and VS stable. Continue to monitor. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's progress notes dated 06/15/2024 at 6:00 PM documented by RN A reflected: Resident #1 was wheeled from dining room to room by CNA B states resident is acting drowsy. Resident #1 assisted to bed. Resident #1 noted with seizure activity. Unable to speak and noted eyes closed flashing back and forth. VS 97.8, 79, 18, 100/60. O2 Sat 94%. Resident positioned on side. [Telehealth] clinician provided healthcare consultation online with nurse and Resident #1. Seizure noted lasting 3-5 minutes. Resident #1's family member entered room and called residents name and resident was able to open eyes and focus on staff. Resident #1 was still nonverbal but was able to nod. Per [telehealth] clinician verbally to send resident out to ER for further evaluation. Family member aware and left at this time. EMS phoned and in route. Resident transferred to hospital ER. Family member phoned regarding which hospital as requested. Message left. Report phoned to ER. Spoke with ER Nurse. Also informed nurse of pending x-ray to left wrist and hand. DON/ADON notified. Review of Resident #1's physician orders, dated 07/01/24, revealed the resident was transported via ambulance for emergent care due to undisplaced fracture of the distal left radius. Review of Resident #1's progress notes dated 06/15/2024 at 7:50 PM documented by RN A reflected: Head to toe assessment performed. No other injuries at this time. Review of Resident #1's progress notes dated 06/15/2024 at 7:46 PM documented by the telehealth NP for Tele med visit reflected: Primary Chief Complaint: Seizure; History Present Illness: Appears to be having a seizure activity, eyes closed lids flashing, does not open to name called. [family member] in room with patient and nurse. Physical Exam: Exam findings per nurse and video observation. Physical Exam - Notes: Patient observed lying in bed, still in seizure status. Appears to be catatonic (person appears awake but seem unresponsive to environment/others) for observation. Unresponsive to commands by family member or nurse. Orders - ED transfer due to presentation and continued seizure activity. Disposition - Transfer to Emergency Department. Review of Resident #1's progress note dated 06/18/2024 at 1:50 PM documented by LVN C reflected: Resident readmitted to facility, arrived on a reclining chair accompanied by [EMS] driver. [EMS] said she happy to be home with a grin on her face. DR's NP notified at [2:47 PM]. Skin assessed, noted greyish bruising to left hand, no swelling but discomfort with movement. Bruised area on left elbow area from hospital IVs sites. [Resident #1's spouse] notified, Resident with no distress, no pain at this time, able to move all extremities with limited movement to bilateral upper extremities. New orders to STOP Ibuprofen, simvastatin and start on Atorvastatin and Aspirin. v/s 125/65, 70, 18, 97.5., 97% room air. Call light in reach, bed lowest position, water pitcher and resident's snacks in reach. Review of Resident #1's Regional Nurse Consultant's note dated 06/18/2024 at 12:17 PM reflected: Arrived on a stretcher. admitted from a hospital. Admitting Diagnosis: Possible CVA. Has a history of falls. Does not complain of pain. Review of Resident #1's progress note dated 06/19/2024 at 2:34 PM documented by LVN C reflected: Day 2 readmission left wrist and forearm bruised from post fall. No swelling noted. Pain at 4/10 this morning, medicated for pain with Tramadol 50mg, med was effective. Up in WC after shower, participated in therapy. Assisted with toileting every 2 hours, fall risk. Chair alarm in place and functioning. BP 132/67, 77, 97.9, 18, 97% room air. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's progress note dated 06/20/2024 at 10:17 AM documented by LVN C reflected: Day 3 readmission left wrist and forearm bruised from post fall. No swelling noted. Pain to left wrist area, medicated for pain with Tramadol 50mg, med was effective. Review of Resident #1's progress note dated 06/22/2024 at 6:40 AM documented by RN A Reflected: Resident #1 requires daily skilled observation for, circulatory issues, genitourinary issues, musculoskeletal issues, or fracture(s), high-risk medication management, neurological issues, teaching/education, management, and evaluation of care plan. The resident is receiving PT services. OTHER OBSERVATIONS: Skilled charting in place. Resident denies pain/discomfort. Safety precautions in place related to fall risk. Needs anticipated. Continue to monitor. Review of Resident #1's progress note dated 06/23/2024 at 7:04 AM documented by LVN D reflected: Cont. to monitor resident r/t falls up in w/c at nurse station most of shift medicated x1 for left wrist/forearm pain left hand discolored. Review of Resident #1's progress note dated 06/23/2024 at 7:08 AM documented by RN A Reflected: Resident #1 requires daily skilled observation for, circulatory issues, genitourinary issues, musculoskeletal issues, or fracture(s), high-risk medication management, neurological issues, teaching/education, management, and evaluation of care plan. The resident is receiving PT services. OTHER OBSERVATIONS: Skilled charting in place. No acute distress noted. Safety precautions in place related to fall risk. Needs anticipated. Continue to monitor. Review of Resident #1's progress note dated 07/01/2024 at 4:16 PM documented by LVN E reflected: Patient received pain pill at this time per complaining of left-hand pain. The Pain was noted to be a 6 on a scale of 0-10 in the MARS. Review of Resident #1's nurse's note dated 07/01/2024 at 8:12 PM documented by LVN E reflected: Resident got order for left ulna x-ray d/t c/o pain; [radiology service] contacted. Review of Resident #1's progress note dated 07/01/2024 at 8:41 PM documented by LVN E reflected: X-ray report back with impression, acute undisplaced fracture of the distal metaphysis of the left radius in good position, no dislocation. MD notified, and gave order to send patient to ER, called and left message to the DON, notified ADON, and called Ambulance to transport Patient to [hospital ER]. Family member (R/P) notified. Patient not in any distress at this time. The following interviews revealed staff were knowledgeable and were in-serviced on fall protocols, assessing, following-up on changes/injuries, and notifying the appropriate parties: During an interview on 07/24/2024 at 10:45 AM with ADON revealed Resident #1 was alert and able to state her needs. Resident had a history of falls. The ADON revealed the interventions in place to protect Resident #1 from falls were a low bed, fall mat on floor, call light within reach, her personal items close to her, and there were times when Resident #1 was placed the in-TV area or here at the nurses station. Resident #1 would still try and get up. The ADON stated the steps nurses are to follow when a resident has a witnessed or unwitnessed fall. Complete a full assessment to check for injuries, contact Physician, family, DON, and Administrator. Order an x-ray right away. Follow-up with Physician with results. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 07/24/2024 at 11:00 AM with LVN F revealed the steps she would follow when a resident has a witnessed or unwitnessed fall. LVN F revealed that when a resident falls, she would complete a full head to toe assessment. If there are no injuries to the resident, resident is assisted up. If resident is injured, contact the Physician for orders for an x-ray. If x-ray shows a break or other injury will send to the hospital for further evaluation. Always have call light within reach, some residents are place in a low bed. LVN F has attended In-services r/t falls, protocols addressing falls, Fall Management. LVN F revealed that there have been several in-services she has attended. During an interview on 07/24/2024 at 11:15 AM with LVN G revealed that the facility has been focusing on Fall Management. LVN G revealed that the Therapy Director held an in-service on Different scenarios r/t to falls. LVN G revealed that a head-to-toe assessment must be completed. If the resident was hurt, it was best to lift resident with a Hoyer and contact the Physician for an order for an x-ray. Notify the DON and the family. If the resident had a head injury send them to the ER immediately. If the order is Stat, they get here within the hour and if it is not stat it could be longer. LVN G revealed she would complete a skin assessment, contact hospital to ask for information r/t the bruise, contact MD, DON, and family. Monitor area to make it does not get worse. She would ask MD for an order for x-ray. LVN G revealed if a previous x-ray order was pending and resident was transferred to hospital before x-ray was completed and you find out that hospital did not complete the x-ray, contact the doctor for an x-ray order, notify the DON, and the family. If resident is in a lot of pain, send to the hospital. If x-ray not follow-up on, resident could have an injury that has not been diagnosed causing more pain to resident. During an interview on 07/24/2024 at 12:27 PM with LVN H revealed that she was familiar with Resident #1. LVN H revealed that staff had to make sure the bed alarm was on Resident #1 while in bed or when she was in the wheelchair. LVN H revealed that the staff would have to set resident near or at the nurses' station to always monitor her. Resident #1 would still try to get up out of her wheelchair. Assessments were completed when a resident fell . In Resident #1's case, the Nurse and CNAs reassess a resident to develop interventions to prevent a resident from falling. Some of the interventions included were low beds, fall mat beside the bed, call light within reach, and keeping everything familiar to resident within reach, keep resident close to the nurses' station, complete a fall assessment, and have PT assess the resident. LVN H revealed she notifies the MD, the family, and the DON. LVN H revealed Nurses were to document in the Risk Management and in the resident's file. LVN H revealed she would contact the MD for X-ray orders. LVN H revealed she would ask the resident what their pain is on a scale of 0 - 10. If they were unable to answer, nurses would document facial expressions. LVN H revealed this would be documented in the PAIN MARS and the resident's progress notes. LVN H revealed the nurses must go behind the CNAs to make sure they are following the interventions. If resident returned from the hospital with a bruise, LVN H revealed she would contact the Doctor, ask the resident what happened if they could tell her, follow up with x-rays if doctor orders them or send them back to hospital per doctor's orders. If a previous x-ray order were pending and resident was transferred to hospital before x-ray was completed and you find out that hospital did not complete the x-ray in the hospital, LVN H would call the doctor to get x-ray orders again. LVN H has been to In-Services held on Falls, Fall Management, Change of Condition, X-Rays. LVN H revealed there have been in-Serviced recently. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 07/24/2024 at 2:40 PM RN A revealed that Resident #1 told CNA B that she had a fall. The fall was an unwitnessed fall on 06/14/2024. RN A revealed that Resident #1 had an injury to her wrist but did not complain of constant pain until 07/01/2024. RN A revealed that an order was received on 06/15/2024 from the NP, but Resident #1 had a seizure and was sent to the hospital on 06/15/2024. RN A revealed in her notes that she informed the ER Nurse there was a pending order for an x-ray for a left wrist and hand x-ray. Resident returned from the hospital on 06/18/2024 and Resident #1's wrist was bruised but not swollen. Resident #1 was not complaining of pain when she returned from hospital. RN A stated she did not know if the hospital completed the x-rays and did not order another x-ray. RN A revealed Resident #1 did not complain of pain on RN A's shift on 07/01/2024 but did complain of pain on evening shift. RN A should have ordered the x-ray the day resident returned from the hospital after reviewing the hospital notes revealed no x-ray completed to Resident #1's left wrist and hand. MRI and a CT scan were completed to find cause of resident's seizure and possible stroke. Failure was that no follow-up was completed r/t concerning x-ray. Resident #1 was having pain in wrist on 07/01/2024. During an interview on 07/24/2024 at 12:51 PM with LVN C revealed she was familiar with Resident #1 and had provided care to her. LVN C revealed Resident #1 has a history of going to bathroom by herself and falls. LVN C revealed staff check the residents every shift, especially for Resident #1. She stated the resident will try and get up out of bed without calling for assistance and after lunch she would try and go from the wheelchair to the bed. Then she falls. LVN C revealed Resident #1 told a CNA B that she fell and got herself up. (06/14/2024) LVN C revealed the nurses found out the next day on 06/15/2024 that the resident had a fall. LVN C recalled that RN A did contact the Doctor for an x-ray order. LVN C stated on 06/18/2024, she documented Resident #1's left wrist and forearm bruised for the next 3 days. Resident was sent to hospital before the x-ray was completed. Resident #1 was readmitted to facility on 06/18/2024. LVN C revealed she did not order an x-ray when she noticed the bruise to the left wrist and hand because the resident was not complaining of pain. Failure occurred during the 3 days due to there was no follow up for x-ray to resident's left wrist and hand until 07.01/2024 when resident began complaining of pain. During an interview on 07/24/2024 at 1:16 PM with CNA I revealed that he is familiar with Resident #1 and has provided care to her. CNA I revealed that Resident #1's bed would be in lowest position. Staff would have to put a bed alarm on her. When she was up in wheelchair, she would have the alarm on. As CNA I revealed that he was not sure when she had a fall. CNA I revealed that the bed is usually low to the floor, a mat next to the floor, the call light close to resident, her things close to her, and be monitored closely. CNA I had attended in-services on Falls, Fall Management, Change of Condition. CNA I revealed that he could not remember all of the in-services, but there have been many. CNA I did say a resident could have complications from not having an x-ray. During an interview on 07/24/2024 at 1:30 PM with LVN E revealed he was familiar with Resident #1 and provided care to Resident #1. LVN E was on duty on 07/01/2024 when Resident #1 began complaining of pain in her left wrist. LVN E gave Resident #1 a pain pill due to the pain she was in. LVN E revealed the wrist was bruised a swollen some. LVN E contacted the doctor to get an order for an x-ray. LVN E revealed the x-ray showed a fracture in the wrist. He contacted doctor with results, DON, ADON, and family. Doctor ordered resident to be sent to hospital. LVN E revealed that he would complete a skin assessment, contact the doctor or an x-ray it a resident returned from the hospital with bruising. LVN E stated if a previous x-ray had been ordered due to resident's fall and resident was sent out to the hospital before the x-ray was completed; then when the resident returned from the hospital he would contact the doctor for an order for x-ray. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455996	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Renaissance at Kessler Park	2428 Bahama Dr Dallas, TX 75211

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 07/24/2024 at 1:45 PM with LVN K to ask questions r/t falls and injuries. LVN K revealed that she worked with Resident #1 on 06/23/2024 and noted resident's bruised left wrist and hand. Medicated resident 1X for pain. LVN K continued to monitor Resident #1's bruised left wrist and hand while on shift. LVN K revealed that if a resident had returned from the hospital with an unexplained bruise, she would complete a full skin assessment. Contact the doctor, the DON, and ADON. If needed ask doctor for an order for x-ray. Contact family. If x-ray shows an injury send resident back to the hospital per doctor's orders. What is the risk if you don't address a change of condition? LVN K revealed we are putting the resident in danger by not addressing their change of condition. Contact the doctor for an x-ray order. LVN K was not aware an x-ray had not been completed on Resident #1. During an interview on 07/24/2024 at 2:00 PM with LVN L to ask questions r/t falls and injuries. LVN L revealed that if a resident returned from the hospital with a bruise or injury, she would complete a skin assessment, call the physician, take orders on what to do. LVN L revealed there is a risk of resident getting worse if there is an injury that has not been addressed. LVN L revealed that you may not know how long the issue has been going on. She would be aggressive in addressing the issue because it could be fatal. If a previous x-ray order was pending and resident was transferred to hospital before x-ray was completed and you find out that hospital did not complete the x-ray in the hospital, LVN L would contact the doctor immediately for x-ray orders. During an interview on 07/24/2024 at 2:10 PM with CNA J revealed that she is familiar with Resident #1. CNA J revealed that inventions have been implemented for resident: low bed, but Resident #1 still would try to get out of bed. Then the staff would raise the bed to keep her in bed. When Resident #1 is up in wheelchair, she would be placed in tv area within eyesight from the nurse's station or at the nurse's station. There would be a chair alarm in the wheelchair and a bed alarm when she was in the bed. If the bed alarm goes off, the staff get the resident back up to prevent a fall. Resident #1's alarm goes off all the time. CAN J believes Resident #1's fall happened in the evening time. Resident #1 can walk a little. CNA J revealed that the staff would constantly tell Resident #1 that staff would not want her to fall. CNA J revealed she saw Resident #1 the last day she was at the facility but did not notice any injuries. CNA J revealed Resident #1 refused the interventions that were in place to prevent her from falling. CNA J has she had attended In-services on Falls, Fall Management, Change of Condition? CNA J Revealed she has attended several In-services in July. During interview on 07/24/2024 at 3:45 PM the DON revealed Resident #1 was fragile, has a cognitive decline, has a poor gait, can walk at times, used a wheelchair. The DON stated the resident sustain a fracture of left wrist The DON stated the nurses contacted the Physician to inform them of the fall. The DON stated when the Dr. orders an x-ray, if it was a regular order, the company could arrive there anytime but if the x-ray was stat, the radiology company should arrive within 4 hours. The DON stated if the resident was in a lot of pain, they are to contact the doctor to get orders to send to the hospital. The DON stated there was an order for an x-ray the day she went to the hospital on 06/15/2024. The nurse informed the ER nurse about the pending x-ray order for the left wrist when Resident #1 was transferred to ER. She stated the nurse called and tried to find if the x-ray was completed in the hospital, but the information could not be found. The DON revealed Resident #1 was not having any pain when she returned from hospital which was why was an x-ray not completed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 07/01/2024 DON/Designee ordered X-ray of Resident #1's left ulna with an impression of an acute displaced fracture of the distal metaphysis of the left radius. The physician was notified of the finding and the resident was sent to the local emergency room and will not be returning to the facility. During an interview and record review on 07/24/2024 at 2:15 PM with the Administrator, DON, and Regional Nurse Consultant revealed documentation r/t Resident #1. They presented documentation for QAPI meeting held in the facility on 07/02/2024 that discussed the timeline of events that occurred with Resident #1's fall from 06/15/2024 - 07/01/2024; Performance Improvement Project Report; Staff Questionnaire r/t Resident #1's injury; and Safe Surveys. The following procedures, audits, and interventions presented to prevent further mistakes in resident's care: The DON/Designee completed a review of all Incident and Accidents for the prior 2 weeks to validate that any resident that required an X-ray had one completed timely if applicable. No other residents were identified as not receiving an x-ray if needed. The Social Service or designee completed alert resident interviews to validate that all residents felt safe and were receiving timely services if applicable. No issues were noted. The DON or designee provided education to all Licensed Nurses and C.N.A.'s on Notification of Change in condition to provide guidance on when to communicate acute changes in status to MD, NP, and responsible party. The DON/Designee provided education to all Licensed Nurses and C.N.A.'s on Fall Management to provide guidance types of falls, fall prevention measures, documentation of falls, investigation and follow up to falls, appropriate interventions with injuries, and follow up. The DON/Designee started reviewing in the morning meeting that any resident with a fall has a new fall assessment and pain assessment completed to alert nurse for possible new interventions. The DON/Designee began reviewing all Incident reports in morning meeting to validate that any resident that required diagnostic testing, had appropriate and timely interventions. The DON/Designee completed a Performance and Improvement Plan which is reviewed daily in the morning meeting to guide the facility in sustaining compliance. Record review of the facility Policy, Radiology and other Diagnostic Services and Reporting Revised: 07/26/2022 indicated the following: The facility must provide or obtain radiology and other diagnostic services when ordered by a physician, physician assistant, nurse practitioner or clinical nurse specialist in accordance with State law. Stat Diagnostic Test - (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- STAT orders will be communicated to the appropriate diagnostic services by facility staff immediately with the expectation they will be performed/collected within 4 hours under normal circumstances. - If the STAT diagnostic test is not performed/collected within 4 hours from contacting the diagnostic service, contact the physician, and DON. Review of in-services and interviews, dated 06/15/2024, with nurses, DON, Regional Nurse Consultant revealed the facility implemented in-services on the following: Topic: Post Fall Management - 06/15/2024 Radiology orders for post fall incidents should be ordered at STAT for best practices. 1. STAT orders will be communicated to the appropriate diagnostic services By facility staff immediately with the expectation they will be performed/ Collected within 4 hours under normal circumstances. 2. If the STAT diagnostic test is not performed/collected within 4 hours from contacting the diagnostic service contact the physician and DON. If the resident is waiting for services to be performed and the injured location appears to be worsening inform the practitioner for potential ER transfer if indicated. Topic: Change of Condition - 07/02/2024 1. CNA or other non-licensed nursing staff recognize a resident's change of condition, the charge nurse must be notified immediately 2. Charge nurse must assess, gather vital signs and ask resident specific question (if possible) about their change of condition 3. Charge nurse must notify MD, resident's family or POA and DON and then document in Progress notes in PCC, add to 24-hour report and alert charting 4. ADONs will audit hospital orders for existing conditions, monitor nurse's notes to ensure there is not issues with resident after return Topic: Fall Demonstration Examples: Man on Floor! What's wrong with this picture? The noncompliance was identified as PNC. The IJ began on 06/18/24 and ended on 07/01/24. The facility had corrected the noncompliance before the survey began.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44894 Based on record review, the facility failed to ensure a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State, where licensing is required for one (Administrator) of one staff reviewed for administrative license. The facility failed to ensure the Administrator's license was current, which expired [DATE]. This deficient practice could result in the facility not being managed in a responsible manner, which could affect the health and safety of all residents. Findings included: Internet search of, https://txhhs.my.site.com/TULIP/s/public-search, revealed the Administrator's license was issued on [DATE] and expired [DATE].