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	06/18/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to provide a resident who was unable to carry out ADLs the necessary services to maintain grooming, and personal hygiene for one (Resident #1) of four residents reviewed for ADL care. Resident #1 ' s brief was soiled, and her bedding had a brown ring around her, with a strong ammonia odor, on 06/18/2025. This failure could affect residents by decreasing quality of life and contributing to skin breakdown. Findings included: Review of Resident #1 ' s face sheet, dated 06/18/25, reflected she was a [AGE] year-old woman, admitted on [DATE], with diagnoses of sepsis (the body responds to an infection by attacking the body ' s own organs), pneumonia (a lung infection), a pressure ulcer, dysphagia (an inability to swallow properly), stroke, and gastronomy status (use of a feeding tube inserted into the stomach). Review of Resident #1 ' s MDS assessment, dated 03/25/25, reflected Resident #1 had unclear speech, impaired vision, was rarely able to understand others, and was rarely understood by others. Resident #1 had short and long-term memory impairment, with severely impaired ability to make daily decisions. She was able to remember staff names and faces, and that she was in a nursing home. A staff assessment of her mood reflected no depression indicators. She was always incontinent in both the bowel and bladder. The document reflected Resident #1 received more than half her nutrition through her gastronomy tube every day of the seven-day lookback period. Resident #1 was dependent on staff for all ADL care. Review of Resident #1 ' s care plans reflected the following care plans: - Focus: ADLs: (Resident #1) has an ADL Self Care Performance Deficit and is at risk of not having their needs met in a timely manner. Performance deficit is related to: Decreased mobility and cognitive deficits, CVA with right sided weakness Date Initiated: 04/11/2022 Revision on: 04/23/2024 Goal: (Resident #1) will maintain a sense of dignity by being clean, dry, odor free, and well-groomed through the next review date. Date Initiated: 04/11/2022 Revision on: 04/02/2025 Interventions: Eating: Total assist x1 with enteral feedings; Toileting: assist x1; Personal Hygiene: Oral care BID, Extensive assist of one; Provide shower, shave, oral care, hair care, and nail care per schedule and when needed. Date Initiated: 04/11/2022. (continued on next page)

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

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	06/18/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Focus: Incontinence: (Resident #1) is incontinent bowel/bladder related to decreased mobility, incontinence and impaired cognition. Date Initiated: 04/11/2022 Goal: (Resident#1) will remain free from skin breakdown due to incontinence and brief use through next review date. Date Initiated: 04/11/2022 Interventions: Check frequently for wetness and soiling and change as needed. Date Initiated: 04/11/2022 · Monitor for and report to MD s/sx UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Date Initiated 04/11/2022. During an observation and interview on 06/18/25 at 09:12 AM, revealed Resident #1 was awake in bed with the head of her bed raised, and a call light clipped next to her. Resident #1 said that she had not been provided incontinent care since last night. Resident #1 said that she was soaked wet. She stated that it happened frequently, especially in the morning. Resident #1 said it was uncomfortable to lie in it, and it was itchy. An observation and interview on 06/18/25 at 09:18 AM, revealed CNA A removed Resident #1 ' s covers to expose her chuck (an absorbent pad placed under incontinent residents) which was soaked yellow with a brown ring around the area where the resident was lying. Her brief appeared to be soaked with urine and BM. The urine had a strong ammonia odor to it. CNA A said that he had changed Resident #1 that morning at 06:00 AM. He said Resident #1 urinated frequently, so she was the first one that he changed (incontinent care) when he started his shift that morning. An interview and observation on 06/18/25 at 09:20 AM revealed CNA A providing incontinent care on Resident #1 with LVN B assisting him. No skin issues were observed on Resident #1 ' s bottom or frontal areas at time of incontinent care. LVN B stated she could smell the strong urine smell and that the brown ring of urine was due to not providing incontinent care timely. LVN B said it was the CNA ' s duty to provide ADL care but nurses helped when needed. She said she, as the nurse, was responsible for making sure that it was done. LVN B said that she gave Resident #1 her medication and checked her blood sugar that morning, but she did not check to see if she was wet. LVN B said the risk was impaired skin and infection, such as urinary tract infections. An interview and observation on 06/18/2025 at 11:38 AM revealed CNA pulling back Resident #1 ' s blanket. Resident #1 was wet, but there was no evidence of a brown urine ring or strong ammonia odor to the urine. The urine was clear in color seen on the chuck pad. CNA A said that he had provided incontinent care to Resident #1 this morning despite what was seen. He said incontinent care was important to prevent skin breakdown and UTI. An interview with Resident #1 ' s family on 06/18/25 at 2:07 PM, revealed the family member had complained to the facility about finding Resident #1 soiled with urine covering her whole bedsheet on multiple occasions, including back in February when Resident #1 was hospitalized for pneumonia and a staph infection. She said Resident#1 could barely feed herself and needed assistance with ADLs and being repositioned. (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	06/18/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 06/18/25 at 3:26 PM, it was revealed the expectation for ADL care and incontinent care was that it be provided in a timely manner, every two hours, or as needed. She said a brown ring of urine around a resident was an indication that they had not been provided incontinent care in a timely manner. She said all nursing staff were responsible for ADL care, and the nurse was responsible for monitoring that it was done. She said the risk to the resident was that it was the resident's right to dignity, and to prevent skin condition and pressure injuries. In an interview with the ADM on 06/18/25 at 4:51 PM, she said the expectation was ADL care was provided for all residents within a timely manner, and as needed. She said the risk to the residents was skin breakdown. Review of Facility policy titled Activities of Daily Living Care Guidelines revision date 02/11/2021, reflected Residents will receive essential services for activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene. The policy did not reflect how often incontinent residents should be changed.

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	06/18/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents receiving enteral feeding received appropriate care and services to prevent complications of enteral feedings for one (Resident # 1) of two residents reviewed for enteral feedings. 1.The facility failed to ensure Resident #1 was not laid flat in bed while her enteral feeding was still running. This failure placed residents with enteral feedings at risk of aspiration (entering the airways or lungs) and hospitalization. Findings Included: Review of Resident #1 ' s face sheet, dated 06/18/25, reflected she was a [AGE] year-old woman, admitted on [DATE], with diagnoses of sepsis (the body responds to an infection by attacking the body ' s own organs), pneumonia (a lung infection), a pressure ulcer, dysphagia (an inability to swallow properly), stroke, and gastronomy status (use of a feeding tube inserted into the stomach). Review of Resident #1 ' s MDS assessment, dated 03/25/25, reflected Resident #1 had unclear speech, impaired vision, was rarely able to understand others, and was rarely understood by others. Resident #1 had short and long-term memory impairment, with severely impaired ability to make daily decisions. She was able to remember staff names and faces, and that she was in a nursing home. The document reflected Resident #1 received more than half her nutrition through her gastronomy tube every day of the seven-day lookback period. Review of Resident #1 ' s physician orders for June 2025 reflected -Enteral feed order every shift [name of brand] 1.5 at 50 ml/Hr for 22 hours, 45 ml/hr water flush Record review of Resident #1 ' s care plans reflected the following care plans: -Focus: (Resident #1) requires the use of a feeding tube and is at risk for aspirations, weight loss, and dehydration. Feeding tube is related to: CVA, DYSPHAGIA & Decreased appetite. Date Initiated: 04/11/2022; Goal: (Resident #1) will be adequately nourished and remain within 5% of her ideal body weight through the next review date. Date Initiated: 04/11/2022; Administer tube feeding and water flushes as ordered. Date Initiated: 04/11/2022; Elevate head of bed 45 degrees or as ordered by physician while feeding tube is being used for feeding and at least 30 minutes after bolus or tube feedings. Date Initiated: 04/11/2022. - Focus: Resident is resistant to getting out of bed and at risk for injury, a decline in functional abilities, and not having their needs met in a timely manner. Date Initiated: 02/28/2025 Goal: · (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	06/18/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident will be clean, well groomed (.) Date Initiated: 02/28/2025 Interventions: Assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain, etc. Date Initiated: 02/28/2025. Review of Resident #1 Medication Administration Record for 06/01/25 through 06/18/25 reflected an order for Enteral Feed Order; Every shift for Aspiration precautions Keep HOB always elevated 30 - 45 degrees - aspiration precautions. Start Date- 03/29/2022 The order was checked off for each applicable shift on those dates. During an observation on 06/18/25 at 11:38 AM, revealed Resident #1 was lying flat on her back with her g-tube connected to the feeding pump running. A display on the pump read RUNNING, FEED RATE 50 ml/hr, FLUSH 45 ml every 1 hrs. The bed remote for adjusting the bed was hooked in the middle of the headboard above Resident#1 ' s head. During an interview with CNA A and LVN B on 06/18/25 at 11:38 AM, it was revealed that they both did not know who had lowered the head of Resident #1 ' s bed. LVN B stated that she always made sure the head of the bed was raised at least 30 degrees to prevent aspiration. CNA A also stated that he was not the one who laid Resident #1 ' s head down. He said that he had been trained to notify the nurse to turn off the pump before lying the resident down. Both CNA A and LVN B both said they were not aware the head of Resident #1 ' s bed was lowered. They said if they had known, they would have raised it. They both said the risk to the resident on g-tube feeding being laid flat on their back was aspiration. In an interview with Resident #1 ' s family on 06/18/25 at 2:07 PM, She said that each time she had come to visit Resident #1 the head of her bed was flat and she had to ask someone to raise it. She said she had never seen Resident #1 adjust her own bed, but she could use the call light, which was never within her reach. She said Resident#1 could barely feed herself therefore she needed assistance with ADLs and being repositioned. Resident#1 ' s family did not recall whom she had spoken to about the bed being flat, but she said the family had notified staff whenever they found the bed down. She said she knew that lying flat while on g-tube feeding could cause aspiration pneumonia. During an interview with LVN E on 06/18/25 at 4:07 PM, he said he had been at the facility for 2 years and the expectation was that the residents during g-tube feeding should have their head of bed up at least 30 degrees. He said if the CNA was providing care, the expectation was that he would be notified so that he could turn off the feeding pump before the resident was laid flat. He said he always checked residents G-tube orders before any medications or restarting feeding after rest time. He said he always checked the g-tube for placement. He said the risk of lying in a resident flat while feeding was running was aspiration. During an interview with the DON on 06/18/25 at 3:26 PM, she stated the expectation for residents receiving nutrition via G-tube continuously was to have the head of the bed elevated at least 45 degrees. The DON said that the nurse was responsible for making sure they followed the policy for the G-tube administration. The DON said the risk for the resident of lying flat during feeding was aspiration. (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	06/18/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the ADM on 06/18/25 at 4:51 PM, she said there were two residents who adjusted their own beds and laid the bed flat, one of them being Resident #1. She said all the staff were aware that Resident #1 liked to lay her bed flat. She said she did not know why LVN B and CNA A did not say so because they were aware of Resident #1 ' s behavior. The ADM said that Resident #1 ' s behavior of lying in her bed flat needed to be care planned moving forward. She said interventions, like that of using a wedge pillow to elevate her upper body while she was feeding, may be used. The ADM said the DON was new and might not yet be aware of Resident #1 ' s behavior of lying flat while on g-tube feedings. Review of the facility policy titled Clinical Practice Guidelines: care of Tube Feed Resident dated 01/20/21, reflected; Keep head of bed (HOB) elevated 30-45 degrees during feeding, keep HOB elevated for 30 minutes after feeding. If necessary to lower the HOB for a procedure turn off tube feeding, then return the patient to an elevated HOB position as soon as feasible.

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	06/18/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (Resident #1 and Resident #2) of four residents reviewed for infection control. 1.LVN B, LVN D, and CNA A did not wear gowns for PPE for Resident #1 who was on EBP during incontinent care and linen change. 2. The facility did not keep Resident #1 and Resident #2 ' s feeding pump pole free of a brown, thick substance, and a sticky dirt substance on both the poles, and the floor under the poles, while using the poles to feed Resident #1 and Resident #2. These failures affected residents by placing them at an increased and unnecessary risk of exposure to communicable diseases and infections. Findings included: Resident#1 Review of Resident #1 ' s face sheet, dated 06/18/25, reflected she was a [AGE] year-old woman, admitted on [DATE], with diagnoses of sepsis (the body responds to an infection by attacking the body ' s own organs), pneumonia (a lung infection), a pressure ulcer, dysphagia (an inability to swallow properly), stroke, and gastronomy status (use of a feeding tube inserted into the stomach). Review of Resident #1 ' s care plans reflected the following care plans: Focus: Enhanced Barrier Precautions; Date Initiated- 04/05/2024; Goal: infection control intervention designed to reduce transmission of multidrug-resistant organisms; Interventions: use of PPE on the anticipated exposure to blood, body fluids, secretions, or excretions. Record review of Resident #1 ' s Medication Administration Record for 06/01/25 through 06/18/25 reflected an order for Enhanced Barrier Precautions for wound care, and g-tube care. every shift for EBP -Start Date- 04/18/2024 The order was checked off for each applicable shift on those dates. During a continuous observation on 06/18/25 from 09:18 AM to 09:50 AM, Resident #1 was connected to a feeding pump that was attached to a dirty pole. The pole was dirty with yellow and brown sticky substances on the pole and on the floor under the pole. Continuous observations also revealed Resident #1 had signage over her bed that read: Gloves and gowns should be donned if any of the following activities were to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity. Perform hand sanitation before entering the room and prior to leaving the room. CNA A and LVN B started to provide incontinent care and linen change. Neither CNA A nor LVN B wore a gown for PPE for a resident on EBP during incontinent care and linen change. (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	06/18/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/18/25 at 09:50 AM revealed LVN D walked into Resident #1 ' s room while CNA A and LVN B provided incontinent care and linen change for Resident #1. LVN D did not put on a gown; she wore gloves and stated she was going to complete a head-to-toe skin assessment while the residents ' skin was exposed. CNA A asked LVN D to get him linen before she got started and handed her the bag that was used to throw the used wipes, soiled diaper, and used gloves. LVN D returned to Resident #1 ' s room after disposing of the trash bag and getting linen. LVN D did not put on a gown for EBP. Resident #1 reported that her skin was itchy and LVN D put lotion on both the residents ' upper thighs and arms. No gowns were observed during this observation in the room, or outside of the door to the room. The isolation cart was observed to be empty. During an interview with LVN B on 06/18/25 at 09:58 AM, she stated it was the responsibility of anyone who noticed the IV pole and pump were dirty to clean them. She said that she did not notice the status of Residents#1 ' s pole, and had she noticed she would have informed housekeeping to clean it. LVN B stated the facility was a professional building and if someone looked around in Resident #1 ' s room and saw the dirty pole they would say we are not following infection control. LVN B stated that she was aware of EBP, and she should have worn a gown during incontinence care and linen change for Resident #1. LVN B said she forgot to wear one. She said wearing a gown was for Infection control. In an interview with CNA A on 06/18/25 at 10:00 AM, he said there were no gowns in Resident #1 ' s room, and he forgot to tell the central supply person to restock. He said that he was overwhelmed by being watched to provide incontinent care and that he was more focused on doing it the correct way that he forgot to wear his gown. He said EBP was for residents with tubes including g-tube and staff were supposed to wear gowns during care. He said the risk was for infection. Resident#2 Review of Resident #2 ' s face sheet, dated 06/18/25, revealed the resident was a [AGE] year-old male readmitted on [DATE] with diagnoses of sepsis (a serious condition in which the body responds improperly to an infection), other specified disease of intestine, Gastronomy status (fed by a tube into the stomach), infection and inflammation reaction due to indwelling urethral catheter (a tube that is inserted through the urethral to drain urine from the bladder into a bag). Review of Resident #2 ' s care plans reflected the following care plans: Focus: Enhanced Barrier Precautions; Date Initiated- 04/05/2024; Goal: infection control intervention designed to reduce transmission of multidrug-resistant organisms; Interventions: use of PPE on the anticipated exposure to blood, body fluids, secretions, or excretions. During an observation on 06/18/25 at 10:11 AM, revealed Resident #2 was connected to a feeding pump attached to a dirty pole. The pole was dirty with yellow and brown sticky substances on it. Above Resident #2 was a signage for EBP which read; Gloves and gowns should be donned if any of the following activities were to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, trach care, bathing, or other high-contact activity. Perform hand sanitation before entering the room and prior to leaving the room. Resident #2 ' s room did not have any gowns in the room. The isolation cart was empty. (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	06/18/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with RN C on 06/18/25 at 10:15 AM, it was revealed that Resident #2 ' s room did not have gowns in the isolation cart. RN C said that the Central supply person was responsible for refilling the isolation carts. He said the nurses and CNAs were responsible for monitoring and reporting to central supply if they needed more PPE. He said that he did not notice that the isolation was empty today otherwise he would have reported it. RN C said that he was aware of EBP precautions for MDRO ' s in residents with medical lines such as catheters, g-tubes, and wounds. He said the risk for not following infection precautions was the spread of infection. RN C said the pole in Resident #2 was dirty, but it was also old, and it appeared to have Rust or dirt and feeding on it. He said that he would tell the housekeeper to clean. He said all equipment should be kept clean for infection control. During an interview with housekeeping on 06/18/25 at 11:50 AM, it was revealed that the nurses were responsible for cleaning the pumps and feeding poles. She said that she was not aware that it was her responsibility. She said that unless the nursing staff asked her to clean it, she did not pay attention to medical equipment. She said that she has no problem cleaning and sanitizing equipment for infection control, had she been told. In an interview with LVN D on 06/18/25 at 1:13 PM, she stated she did not have to wear a gown for EBP for Resident #1 because she was not giving any medication via G-tube. She said that if she was not accessing the g-tube she did not need to wear PPE for EBP. She said EBP was used on residents with wounds, g-tube, dialysis ports and catheter. She said EBP was only needed when accessing those things. She said there was no Risk to Resident #1. In an interview with the Central Supply Coordinator on 06/18/25 at 1:26 PM, she said the isolation cart was restocked on Monday, Wednesday, and Friday. She said that if more gowns or supplies were needed the charge nurse had keys to central supply where they could get more items. She said that she did not work Monday and that could be why the gowns were out, but anyone could have refilled without waiting for her. She said PPE was important for infection control. During an interview with LVN E on 06/18/25 at 4:07 PM, he said he had been at the facility for 2 years. He said EBP was followed by wearing a gown, gloves, and mask if needed. He said EBP was to protect the residents and self from transferring infection. He said that they had enough PPE, and he had gone to central supply to get supplies when they have been out. He said everyone was responsible for notifying the right people when supplies were out. During an interview with the DON on 06/18/25 at 3:26 PM, she said the expectations were for a resident on EBP to have a sign on the door. EBP was to be followed for wounds, g-tube, trach, IV, and catheter. She said the expectation was that PPE was worn when staff were providing direct contact such as ADL because there was care potential for MDRO infections. She said all rooms with any isolation including EBP should have PPE readily available. She said the expectation was to have supplies restocked when they were low. She said PPE was worn for protection of the residents and of self, to be free of contamination. She said if PPE was not available the staff were to ask someone to get it. The DON said it was the responsibility of the Central Supply Coordinator, the ADON, and the DON to monitor that there was PPE and to make sure that they looked over the order supplies list. She said EBP was expected to be followed for infection control. The DON said IV poles should be kept clean by housekeeping and cleaning should be done daily. She said nurses were responsible for monitoring the equipment that was cleaned. She said communication was done with the housekeeping supervisor. She said the risk was when things were not cleaned was, they could have pests and bacteria. (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	06/18/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the ADM on 06/18/25 at 4:51 PM, she said the expectation was that they had PPE available and to notify her immediately if they ran out. She said the responsibility was for the Central Supply Coordinator to make sure that they all had what they needed, and to notify her if they did not. She said having PPE was important to make sure they were taking proper precautions against infection. She said they were all responsible, including nursing, to have the proper supplies to do their work. The ADM said housekeeping staff were responsible for cleaning all equipment. She said she expected the nursing staff to tell them. She said that she would contact the contract housekeeping supervisor so that everyone was on the same page as to who was responsible for keeping equipment clean. She said staff would be educated in clean environments to prevent infection. The ADM said EBP policy and procedure should be followed. She said she was not sure why CNA A, LVN B and LVN D did not do it. Review of policy Infection Prevention and Control Program review date 03/26/24, reflected, . EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following: a. Infection or colonization with an MDRO when Contact Precautions do not otherwise apply b. Wounds and/or indwelling medical devices (e.g., central lines, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status During high-contact resident care activities: · Dressing · Bathing/showering · Transferring · Providing hygiene · Changing linens · (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	06/18/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Changing briefs or assisting with toileting · Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator · Wound care: any skin opening requiring a dressing . Record review of facility policy Clinical Practice Guidelines: Cleaning and Disinfecting Portable Equipment dated 05/04/21, reflected . It is the policy of this facility to follow infection control principles to prevent spread of infection through contact with portable equipment in the resident ' s care environment .