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	08/29/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43843 Based on observation, interview and record review the facility failed to serve food in accordance with professional standards for food service safety for 1 of 1 facility kitchen reviewed for food safety. The facility failed to use one utensil for each food item served during lunch. This failure could place residents at risk for food-borne illness and food contamination. Findings include: Observation on 08/28/2024 at 11:55 AM revealed [NAME] D used the same tongs to pick up and serve both pork loin and beef patties. [NAME] D repeated the serving actions again at 11:58 AM Observation on 08/28/2024 at 12:08 PM reflected [NAME] D used the tongs previously used to pick up pork loin and beef patties to pick up French fries. Interview on 08/28/2024 at 12:21 pm with [NAME] D revealed there was only one pair of tongs to use during lunch service. [NAME] D stated the risk of using one utensil to serve multiple food items would be food transfer. Interview on 08/28/2024 at 1:18 PM with Dietary Manager reflected each food item was supposed to have its own serving utensil. He stated that there were not enough tongs for each food item. The Dietary Manager stated the risk of using the same utensil to serve multiple food items placed the residents at risk of cross contamination. Record review of the facility's policy Food Safety and Sanitation Plan review date 07/22/2021 reflected nursing home residents risk serious complications form food borne illness as a result of their compromised health status. Unsafe food handling practices present a potential source of pathogen exposure for residents. Sanitary conditions must be present inl health care food service settings to promote safe handling.

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 35489 Based on observation, interview and record review, the facility failed to ensure, in accordance with accepted professional standards and practices, the medical record was maintained on each resident that were complete and accurately documented for 1 (Resident #49) of 8 residents records reviewed for treatment documentation. The facility failed to ensure Resident #49's orders for his tracheostomy and tracheostomy care were in the EMR. This failure could affect any resident, placing them at risk of inaccurate information and resulting inappropriate care. Findings included: Review of Resident #49's Admission Record, dated 08/29/24, reflected he was a [AGE] year-old male originally admitted on [DATE], and most recently readmitted on [DATE], with diagnoses of anoxic brain damage (brain damage from lack of oxygen), tracheostomy status (surgically inserted tube into airway for breathing), and acute and chronic respiratory failure with hypoxia (a condition in which the lungs do not properly exchange oxygen for carbon dioxide, resulting in low oxygen in the body.) Review of Resident #49's Quarterly MDS assessment, dated 07/30/24, reflected he was rarely or never understood, and rarely or never understood others. The staff assessment of memory reflected he appeared to have long and short-term memory problems, and severely impaired daily decision-making skills. Resident #49's range of motion was impaired on both sides of his body, in both upper and lower extremities. He was entirely dependent on staff for all care. The document reflected that Resident #49 had received oxygen therapy, tracheostomy care, and suctioning of his tracheostomy while a resident at the facility. Review of Resident #49's care plans reflected the following: Resident has a tracheostomy and is at risk for potential complications such as weight loss, increased secretions, congestion, infection, and respiratory distress. TRACHEOSTOMY TYPE: Shiley, size: 8.5 mm, secure with tracheostomy ties. Date Initiated: 03/14/2022 Revision on: 06/04/2024 o Resident will have clear airways with adequate ventilation through the next review date. Date Initiated: 03/14/2022 Revision on: 04/03/2024 Target Date: 09/05/2024 o Resident will have no signs or symptoms of infection at the tracheostomy site through the next review date. Date Initiated: 03/14/2022 Revision on: 04/03/2024 Target Date: 09/05/2024 o Administer medication as needed/ordered by the physician for episodes of anxiety. Provide support to prevent anxiety when episodes of shortness of breath occur. Date Initiated: 03/14/2022. Provide oxygen, humidity, tracheostomy care, and tubing changes as indicated by physician's orders Trach Size: 8.5 mm ID 7.5mm disposable inner cannula. Date Initiated: 03/14/2022; Revision on: 06/04/2024. Ensure that trach ties are secured at all times. Date Initiated: 03/14/2022 o Suction as needed for increased secretions and congestion. Date Initiated: 03/14/2022. Provide oral care daily and as needed. Date Initiated: 06/04/2024. Monitor/document for restlessness, agitation, confusion, increased heart rate (Tachycardia (rapid heart rate)), and bradycardia (heart beating too slowly). Date Initiated: 03/14/2022. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #49's orders in the EMR on 08/29/24 reflected the only mention of a tracheostomy to be Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083% (Albuterol Sulfate) 1 vial via trach four times a day related to ACUTE RESPIRATORY FAILURE WITH HYPOXIA. Review of Resident #49's MAR on 08/29/24 reflected no tracheostomy care documented for the month of August 2024. Review of a hand-written Respiratory Therapy note, dated 08/24/24, reflected the Respiratory Therapist had observed Resident #49 in his bed, and noted the resident was comfortable and noted the resident was not on oxygen. Review of a nursing progress note dated 08/26/24 reflected tracheostomy care had been provided by LVN A. Review of a nursing progress note dated 08/27/24 reflected a note by LVN B: (.) trache also in place with PRN care being given suctioned times, one [sic] this shift Aspiration precautions maintained Will treat as ordered Review of a nursing progress note dated 08/27/24 reflected a note by LVN C: Trache in place clear secretions. Review of a nursing progress note dated 08/28/24 reflected a note by LVN B: Resident has trache in place tha [sic] requires PRN suctioning. Suctioning [sic] required once this shift with clear ;thin secretions being expelled. Review of a nursing progress note dated 08/29/24 reflected a note by the ADON: Trach care provided by this nurse for charge nurse, secreations [sic] clear with no complications while suctioning resident and providing patch care. Review of a nursing progress note dated 08/29/24 reflected a note by the ADON: Trach care provided by this nurse for charge nurse, secretions clear and scant, resident tolerated well. Review of an untitled document provided by the ADON, dated 08/29/24 3:08 PM reflected a full set of phone orders for Resident #49's tracheostomy care, addressed from the facility to the prescribing physician. Observation of Resident #49 on 08/27/2024 at 9:32 AM revealed him to be awake in his bed, and to have a tracheostomy. No obvious concerns were observed by the surveyor. Observation of Resident #49 on 08/29/2024 at 10:00 AM revealed him to be asleep in his bed, and to have a tracheostomy. Resident #49's tracheostomy had a humidifier, but was not connected to oxygen. No obvious concerns were observed by the surveyor. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 08/29/24 1:17 PM with LVN B revealed Resident #49 was able to expel his excretions by coughing pretty well, so she usually only had to suction him once per shift, and it was important to not over-suction someone. She said that part of the care for the tracheostomy was to keep it clean and dry, change the gauze, and notice if there were any changes or concerns. She said Resident #49 was not alert, and was completely dependent on the staff, due to a brain injury, so they had to check on him. She said he was not on oxygen, only humidification, and was doing very well. An interview on 08/29/24 at 3:12 PM with the ADON revealed it had just been brought to her attention by staff that there were no orders for Resident #49's tracheostomy care in the EMR, and she had responded by putting them in immediately. She expressed that she was baffled, because she knew they were there, and she was investigating, but had not figured out what happened. She explained that Resident #49 was not a new admission, and had been in and out of the hospital. She said when he readmitted , their corporate would have deleted all of his previous orders, as was best practice, because someone could come back with new orders from the hospital that did not match their old ones. When he returned they would enter batch orders. They were standing orders that were grouped together, which would come into the queue in the EMR, and the admitting nurse would go through and verify them, and activate them. She said the orders might be things like an order to crush meds if necessary, and in this case, they would manually add the batch orders for a specific type of tracheostomy. The physician would approve the orders, then the resident would be evaluated by the respiratory therapist, and they might write new orders, if needed, which would be entered into the EMR. When someone was admitted it was the admitting nurse's responsibility to add any type of order. She said she had been asking questions of the staff, and she knew she had seen orders in for Resident #49, and his nurse also had seen them. She said they did not have any PRN or agency nurses working at the current time, and the nurses fortunately knew Resident #49's care, and had documented at least per shift in the progress notes, but they would normally check the care off in the MAR, as well. She said the orders directed the care, and it was possible that missing orders could cause someone to not receive appropriate care. An interview with the Administrator on 08/29/24 at 3:48 PM revealed her expectation was that the nurse would enter orders when a resident was admitted . She said they knew they were there, and it was like someone had hit the delete button on them. She said they were looking into what happened, but something was wonky. She said not having orders in the EMR could cause someone to receive improper care. Record review of the facility's policy titled Medication Reconciliation, dated 09/24/22, reflected Policy: This facility reconciles the resident's medications to ensure the resident is free of any significant medication errors. Definitions: Medication reconciliation refers to the process of verifying that the resident's current medication list matches the physician's orders for the purpose of providing the correct medications to the resident at all points throughout his or her stay. Policy Explanation and Compliance Guidelines: 1. Medication reconciliation involves collaboration with the resident/representative and multiple disciplines, including admission liaisons, licensed nurses, physicians, and pharmacy staff. (.) 3. Pre-Admission Processes: a. Obtain current medication list from referral source (i.e. hospital, home health, hospice, or primary care provider). b. Obtain current medication/admission orders. (.). d. Forward to nursing unit accepting the resident. (.) 4. Admission Processes: (.) b. Compare orders to hospital records, home or orders from healthcare entity, etc. Obtain clarification orders as needed. c. Transcribe orders in accordance with procedures for admission orders. d. The DON/designee reviews transcribed orders for accuracy and cosign the orders, indicating the review.