

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675081	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER Golden Acres Living and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 Centerville Rd Dallas, TX 75228	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42214</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely for 1 (Resident #1) of 7 resident rooms reviewed for environment.</p> <p>The facility failed to ensure the call light system in Resident #1's room (Room L080) was in good repair.</p> <p>This failure placed residents at risk of possible injury due to an unsafe environment.</p> <p>The findings included:</p> <p>Record review of Resident #1's face sheet, printed on 07/03/24, revealed a [AGE] year-old female who admitted to the facility on [DATE], with diagnoses of cerebrovascular disease (conditions that affect blood flow and vessels to the brain), protein-calorie malnutrition, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side (paralysis and partial weakness), encephalopathy (brain dysfunction), and vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain).</p> <p>Record review of Resident #1's annual MDS assessment, dated 12/21/23 revealed Resident #1 had a BIMS score of 15, which indicated Resident #1 was cognitively intact.</p> <p>Record review of Resident #1's care plan, revised on 04/23/24, revealed the following:</p> <p>Focus: At risk for falls r/t Hx of falls, muscle weakness, cognitive decline, poor mobility, seizure d/o, cardiac issues, CVA w/</p> <p>hemiparesis and hemiplegia, confusion and forgetfulness, poor safety awareness and chronic UTI. Impulsive to do things by</p> <p>herself even if she is unable . Interventions: Be sure the call light is within reach and encourage to use it for assistance as needed.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview and observation on 07/03/24 at 1:47 p.m., Resident #1 stated she was well, and she had no concerns regarding the care she received at the facility. Resident #1 stated her only concern was the condition of the call light wall mount, which was observed to be hanging from the wall with electrical wiring exposed. Resident #1 stated the call light still worked but she was afraid to use the light because she did not want to pull it further out of the wall, especially while she was in bed. Resident #1 stated the call light had been hanging from the wall for about a week. Resident #1 stated she had not reported the call light to facility staff because she assumed they knew, as staff had recently been in her room for other maintenance concerns.</p> <p>In an interview on 07/03/24 at 2:15 p.m., CNA B stated she was the aide assigned to hall L1, which was where Resident #1 resided. CNA B stated she was not aware of the condition of Resident #1's call light. CNA B stated if they saw maintenance concerns, they were trained to report the issue to the charge nurse who would submit a maintenance request.</p> <p>In an interview on 07/03/24 at 2:21 p.m., ET C stated he was an engineer technician who reported to the EGD, who was on leave at the time of investigation. ET C stated it was his responsibility to answer maintenance requests, ensure the facility's air conditioning unit was operable at all times and he handled any pest control issues within the facility. ET C stated he was not aware of the condition of Resident #1's call light. ET C stated if facility staff saw any maintenance issues within the facility, they were to submit a request in the electronic maintenance request system so it could be repaired. ET C stated he was in Resident #1's room the week prior to the investigation, and he did not notice the call light hanging from the wall. ET C stated call lights that were not properly mounted on the wall could work improperly and cause a delay in assistance for the resident. ET C stated he was going to repair the call light in Resident #1's room and speak with the EGD about starting an in-service of reporting maintenance requests.</p> <p>In an interview on 07/03/24 at 2:39 p.m., LVN E stated she was the charge nurse for hall L1, which was the hall Resident #1 resided on. LVN E stated she was not aware of the condition of Resident #1's call light, but she remembered an aide stating a few days ago, that a call light was hanging from the wall and the aide pushed the call light back into the wall and kept going. LVN E stated she could recall which aide told her. LVN E stated any maintenance issue should be entered into the electronic maintenance system, as not doing so could prolong needed repairs and cause a delay in care if the call light had become inoperable.</p> <p>In a telephone interview on 07/03/24 at 2:54 p.m., the ADMIN stated it was expected for maintenance rounds be conducted and any maintenance needs be addressed accordingly. The ADMIN stated he was not aware of the condition of Resident #1's call light until he received a call from ET C, prior to speaking to the surveyor. The ADMIN stated Resident #1's call light could have been inoperable, but staff tested the light and it worked, so there was no negative effects for Resident #1. The ADMIN stated he would start an in-service on maintenance reporting to ensure all maintenance concerns were addressed in a timely manner.</p> <p>Record review of the facility's policy entitled Safe / Comfortable / Homelike Environment and revised in January of 2022, reflected in part:</p> <p>Policy: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible</p>		