STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675196	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Park Health and Rehabilitation Center	1720 N McDonald McKinney, TX 75069

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747 Based on observation, interview, and record review the facility failed to ensure assessments accurately reflected a resident's status for one of eighteen residents (Resident #4) reviewed for accuracy of assessments. The facility failed to ensure Resident #4's MDS Assessment accurately reflected their urinary status. This failure could place residents at risk of not having their needs identified and not receiving necessary care. Findings include: Review of Resident #4's Face Sheet, dated 04/26/24, reflected he was a [AGE] year-old male who initially admitted to the facility on [DATE]. Review of Resident #4's MDS Assessment, dated 03/08/24, reflected Resident #4 had diagnoses including parkinsonism (a disorder of the central nervous system that affects movement, often including tremors), diabetes mellitus (a group of diseases that result in too much sugar in the blood), and dysphagia (difficulty swallowing). The MDS Assessment reflected Resident #4 utilized an indwelling urinary catheter (a catheter that is left in the bladder and that collects urine by attaching to a drainage bag). Review of Resident #4's MDS Assessment (State Optional), dated 03/08/24, did not address whether or not Resident #4 utilized a urinary catheter. Review of Resident #4's Physician's Orders, dated 04/26/24, reflected Resident #4 previously had a urinary catheter that was discontinued on 01/12/21. Review of Resident #4's Care Plan, dated 02/23/24, reflected he had bladder incontinence. Identified goals included for Resident #4 to remain free from skin breakdown due to incontinence and the use of adult briefs. Interventions included staff cleaning Resident #4's peri-area with each incontinent episode. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #4 on 04/24/24 at 12:33PM revealed he was clean, well-groomed, and appropriately dressed. He was free from any odors. He displayed no obvious signs or symptoms of distress. Resident #4 was not observed to utilize a catheter. An interview with Resident #4 was attempted on 04/24/24 at 12:33PM; however, Resident #4 was unable to participate in an interview due to his cognitive status. During an interview with LVN E on 04/26/24 at 1:09PM, she stated she had worked at the facility for a couple of years and provided regular care for Resident #4. LVN E stated to her knowledge, Resident #4 had never utilized a urinary catheter. During an interview with the MDS Nurse G on 04/26/24 at 1:44PM, she stated Resident #4 did not utilize a urinary catheter. She stated there was a documentation error on the MDS Assessment that was completed on 03/08/24. MDS Nurse G said she thought she had rectified the documentation error when she completed an updated MDS Assessment (the State Optional assessment); however, it did not appear as though the error had been corrected. MDS Nurse G said the risk of inaccurate MDS Assessments included potential funding discrepancies and inaccurate quality measures. Review of the facility's Minimum Data Set (MDS) Policy for MDS Assessment Data Accuracy, dated 02/2021, reflected, .Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that: 1. The assessment accurately reflects the resident's status .

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F 0645

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

PASARR screening for Mental disorders or Intellectual Disabilities

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 28637

Based on record review and interviews, the facility failed to complete an accurate PASARR evaluation on residents prior to admission and after admission for 1 of 7 residents reviewed for PASARR screenings (Resident #19).

The facility did not correctly identify Resident #19 has having mental illness diagnoses and failed to correct his PASARR Level 1 screen to reflect the information.

This failure placed residents at risk of not receiving or benefiting from specialized therapy and equipment services they may require.

Findings included:

Record review of resident #19's Admission Record revealed he was a [AGE] year-old male admitted to the facility on [DATE] from another nursing facility.

Record review of Resident #19's Admission MDS assessment dated [DATE] revealed he had moderately impaired cognition and active diagnoses including traumatic brain injury (brain damage caused by an outside force such as a blow to the head during an accident) , depression, bipolar disorder, and post-traumatic stress disorder (PTSD).

Record review of Resident #19's Quarterly MDS assessment dated [DATE] also revealed he had moderately impaired cognition and active diagnoses including traumatic brain injury, depression, bipolar disorder, and post-traumatic stress disorder.

Record review of resident #19's History and Physical dated 3/1/24 reflected his diagnoses included bipolar disorder, PTSD, and traumatic brain injury.

Record review of Resident #19's PASRR Level 1 Screening dated 1/12/24 reflected he had no indicators for mental illness.

An observation of Resident #19 on 4/24/24 at 11:10 AM revealed he was dressed and sleeping in his bed. He did not respond to a knock on his door.

In another observation and interview on 4/25/24 at 11:54 AM revealed Resident #19 was lying in bed, he was dressed appeared disheveled. He denied complaints and stated he was sleepy because he had stayed up late watching movies.

During an interview on 4/25/24 at 12:05 PM, LVN B stated Resident #19 refused care and showers at times. She stated the CNA's made attempts to talk him into care but they did not press him because he would become agitated.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/26/24 at 9:13 AM, MDS Nurse A stated she submitted PASARR forms for the facility. She stated she had received Resident #19's PASRR Level 1 Screening form from his transferring facility. She stated she did not recall noticing he had no indicators for Mental Illness on the form and should have verified it. During a follow-up interview with MDS Nurse A on 4/26/24 at 11:42 AM, she stated she had just submitted a correction form to the State. She stated the risk for inaccurate PASARR forms was a resident could miss out on potential services that may be available for them. During an interview with the Administrator on 4/26/24 at 2:05 PM, she stated she had been made aware of the inaccurate PASARR screen. The Administrator stated failing to have Level 2 screenings completed placed residents at risk for not being provided proper services. Record review of the facility's policy and procedure titled, PASRR Level 1 Screen Policy and Procedure, dated Revised 3/6/19 reflected: Policy: It is the policy of Creative Solutions in Healthcare facilities to obtain a PL1 screening form from the RE (referring entity) prior to admission to the NF. The PL1 will be submitted via [computer portal] timely per PASRR Regulatory timeframes. PASRR is a federally mandated program requiring all states to pre-screen all individuals seeking admission to a Medicaid-certified nursing facility, regardless of payor source or age. The PASRR Program is important because it provides options for individuals to choose where they live, who they live with and the training and therapy they need to live as independently as possible Procedure: 1. The Facility Admissions process will ensure a PL1 Screening Form is obtained from the RE on day of admission or prior to admission. A PL1 is obtained for every individual, regardless of payment type, seeking admission to a Medicaid-certified NF. 2. The PL1 Screening Form is completed by the RE (referring entity) using the paper copy of the PL1 Screening Form. 3. The Facility will review the PL1 Screening Form for completion and correctness prior to admission and submit the PL1 form per regulations. The Type of Admission is reviewed for correctness. Ensure the Name, SS number, Medicare/Medicaid numbers and DOB is correct. The Date of the PL1 is correct (i.e. correct day, month and year) and review each item on the PL1 to ensure accuracy and prevent a regulatory problem

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47030 Based on observation, interview, and record review, the facility failed to ensure residents were free of accident hazards and received adequate supervision to prevent elopement for 1 of 6 residents (Resident #20) reviewed for accidents and hazards. The facility failed to ensure that after hours when there was not a front entry receptionist that the front door was secure before Resident #20 successfully eloped on 04/21/24 to the front patio. This failure placed residents at risk of elopements. The findings were: Record Review Resident #20 with admitted [DATE] care plan that was implemented on 03/07/24 reflected problem.Resident#20 is at risk for wandering., with interventions of Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise. Record review of elopement assessments for 02/01/24 through 04/25/24 revealed the following: - 02/20/24 revealed the resident scored a 7. - 03/06/24 revealed the resident scored a 21. - 04/22/24 revealed the resident scored a score of 24. An elopement assessment score of 10 or greater indicate the resident is considered an elopement risk. Record review of progress note dated 04/21/2024 at 10:06pm revealed, with resident diagnoses: Cognitive communication deficit, need for assistance with personal care, unspecified, vascular dementia, and unspecified severity, with agitation. Author: LVN F wrote, Resident found out of the facility propelling wheelchair herself, staff found her by the facility parking way. Resident on 15min check, RP notified, will continue monitoring. Record review of psychological assessment completed on 4/2/24 reveal the resident's history of present illness of declining cognition and wandering out of her RP's house while living with the RP in November and December of 2023. Record review of the BIMS (Brief Interview for Mental Status) a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility. BIMS was completed on 4/16/24 with a score of 7 indicating severe cognition impairment. BIMS revealed resident used a manual wheelchair for mobility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 04/24/24 at 10:00am revealed Resident #20 on 4/24/2024 on the secure unit sitting up in a recliner in her room, without a wander guard. Observations throughout the investigation 04/24/24 to 04/26/24 revealed a busy street the front entrance of the facility. Interview on 04/25/24 at 09:10 AM with LVN D indicated she had worked at the facility since 2017 but for the past 2 years was an as needed worker. LVN D was working on the 300hall/secure unit. LVN D showed surveyor each of the doors in the 300 hall/unit; there were a total of 3 doors and 2 gates. LVN D revealed she did not have the code to open the gates. LVN D was unable to identify which residents on the 300 hall/secure unit had the wander guards and was unfamiliar if there were a list. LVN D said there was no routine for checking the doors and locks. Nurses and aids interact with the residents ongoing throughout their shift along with routinely, no more than every 2 hours check on residents that are in their room. Interview on 04/26/24 at 09:43 AM Aide A that worked on the secure 300 hall/unit said one way to prevent residents for elopement risk was to watch the residents closely especially on 300 hall/secure unit. Interview on 4/25/24 at 10:00am with the Administrator clarified resident #20 was on the 500 hall when she eloped and after the elopement was moved with her RP's consent to the 300 hall/secure unit. The Administrator discussed which doors in the entire facility had the wander guard alarm, there were a total of 3. 1-the front door, 2-patio door where the resident's go to smoke, 2-door to laundry. The Administrator revealed the 2 gates on the 300hall/secure unit patio have a keypad but no alarms. The Administrator revealed the exterior door leading to the patio does not sound but had a keypad. The Administrator revealed resident#20 did not have a wander guard because she is on the 300hall/secure unit. Resident had wander guard when she was on the 500 hall. The Administrator revealed the staff on the 500 hall had completed personal care with the resident at 9:45/9:50pm on the night resident #20 eloped. Aides check on the residents at minimum every 2 hours, when they ring their call light and as needed. Interview on 4/25/24 at 10:30am with LVN C, who works on the 500 hall, on 4/25/24 at 10:25am who works on the 500 hall but did not work the night of the elopement on 4/21/24 at 1:52pm LVN C revealed resident#20 would wander/wheel around the facility, but he never saw resident #20 pushing on a door trying to leave. Supervision described as closely watching the residents and at minimum make compliance checks every 2 hours when the resident is in their room. During a telephone interview at 10:45am on 4/25/24 with Aide B stated she had moved her car from the back of the building to the front of the building. Aide B revealed she saw the patient sitting in her wheelchair out front of the facility alone. Aide B assisted the resident back into the building. Aide B reported another Aide was inside the building approaching the front door. Aide B reported the door alarm was not going off. Interview on 4/25/24 at 12:49pm RP acknowledged Resident #20 had a wander guard while on the 500 hall but did not have a wander guard now due to being on the secure 300 hall/unit. Interview 4/25/24 with Aide C said she was familiar with resident #20 stating she knew resident #20 wandered the halls but never saw her try to exit the building. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/25/24 at 1:15am with DON said he would have to investigate why the nurse checked off on the Q15 (every 15 minute) minute check list if the LVN E nurse said the resident did not have a wander guard. 4/26/24 at 1:15pm I worked with the various nursing staff on each hall to test each resident's wander guard using the wand for the one resident that did not want to get out of bed. The other 4 were taken to the front door to test the wander guard. As each resident approached the front door a beeping sound began to go off. When staff put in the door code and opened the door as the resident was at the door a loud alarm went off requiring the nurse to put in the code to cancel the alarm. Interview on 04/26/24 at 10:04 AM LVN E last in-service on Abuse Neglect and Exploitation was weekly. Elopement training is often and last week was last time. She said ways to help prevent elopement are to keep completing 15min checks, know resident needs and habits, keep busy with activities, do rounds. Interview on 4/26/24 at 10:30am with Maintenance Specialist indicated there are 3 doors that trigger the wander guards- the front door, the door that leads to the smoking patio, and the door that leads to the laundry building. The door that leads to the smoking patio and the door that leads to the laundry building were tested by Maintenance Specialist using the wander guard pocket Tag reader device; both doors tested positive meaning the alarm sounded as it should if someone is going out of the door. Maintenance Specialist revealed doors are tested monthly and he keeps a log. If doors are not working properly the residents could get out of the building without staff knowing. The resident getting out without staff could be harmful if a resident falls, is out in extreme weather of rain, sleet, heat, or cold. If the resident may not be able to get back into the building if they get out without the alarm going off or if staff do not assist them outside. Record Review of facility's policy Elopement Prevention , dated January 2023, reflected the following: Policy Statement Every effort will be made to prevent elopement episodes while maintaining the least restrictive environment for residents who are at risk for elopement. 1. The Elopement Risk Assessment 2. Identify the cause of wandering. 3. Intervention Strategies 4. Environmental Modification Physical Plant 1. All facility exits that residents have access to will have a device in place to alert staff of elopement attempts. i. Examples of these devices: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ii. Wanderguard System (locking or alarming) 1. Placement of the residents' device to alarm the system will be verified each shift and documented on a treatment or other flow record. 2. Function of the resident's device will be verified at least daily and documented on a treatment of other flow record. 3. Function of the alarm system will be verified each week and documented in a maintenance log. o Keypad exit magnetic locks. o Keyed Alarms o Secured Unit Fire exit doors on the secure unit will meet the following criteria: The lock must be electro-magnetic. The lock must release when any one of the following occurs: The fire alarm or sprinkler system are activated. Power failure to the facility Activation of a switch or button located at the monitoring station and the main nurse's station. o A keypad or buttons may be located at the control door for routine use by staff. o A manual fire pull must be located within five feet of each exit door with a sign stating, Pull to release door in an emergency. o Staff must be trained in the methods of releasing the door device. Or a combination of the above 2. All other exits not considered fire exits will be locked when not occupied by staff members. 3. All exit devices will be maintained by the manufacture's recommendations and function of each device will be verified weekly, and a log maintained.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public for 2 (500 and 600 Halls) of 6 halls reviewed for environment. The facility failed to ensure the walls, floors, and bathrooms were in good repair for rooms 505, 507, 605, 607, 608, and 610. This failure places residents at risk for diminished quality of life due to the lack of a well-kept environment. Findings included: Observation on 4/24/24 at 11:14 AM in room [ROOM NUMBER]A revealed there were multiple scratches in the paint on the walls alongside the bed. Observation on 4/24/24 at 11:16 AM in room [ROOM NUMBER] B revealed the walls alongside and behind his bed had large scrapes in the paint. The scrapes alongside hid bed formed an arc that appeared to have been caused when the head of his bed was raised and lowered. Observation on 4/25/24 at 11:35 AM in the bathroom shared by rooms [ROOM NUMBERS] revealed there was chipped paint along both the door trims. There was a large area beneath the sink approximately 2 feet in diameter with a thick white substance where, it appeared, repairs had been made. An Observation on 4/25/24 at 12:49 PM in the bathroom shared between rooms [ROOM NUMBERS] revealed the base of the door jamb leading to room [ROOM NUMBER] was completely rotted away along the bottom, approximately 3 inch section, exposing rotted wood and debris inside. The white paint above the rotted area was scraped and chipped exposing approximately 12 inches of wood beneath. The linoleum was separated and bubbling along that area. The linoleum extended up the walls inside the bathroom and was peeling away from the wall all along the back wall behind the toilet and the side wall leading to the door that connected the bathroom to room [ROOM NUMBER]. The linoleum was beige in color but had a large black/gray stain that extended from the left side of toilet to the left side wall of the bathroom. An Observation on 4/25/24 at 12:54 PM in the bathroom shared by rooms [ROOM NUMBERS] revealed the area surrounding the plumbing beneath the sink appeared as though a portion of the wall had been cut away then placed back leaving open holes and gaps in the wall. The area extending beneath the opening and the floor had, what appeared to be, a thick layer of uneven plaster covering the area from beneath the sink to the adjacent wall on the left side. The linoleum was bubbled up near the door jamb for room [ROOM NUMBER]. The door jamb on room [ROOM NUMBER]'s side of the bathroom had damaged areas in the wood at the bottom, scrapes and missing paint exposing the wood beneath. There was a hole in the door leading to room [ROOM NUMBER] that was approximately 2 inches by 3 inches along the edge of the door between the middle and bottom hinges . (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/25/24 at 1:00 PM, LVN B, 600 Hall Charge Nurse, stated the facility used an app to report any maintenance issues found or maintenance complaints from the residents. She stated she had used the app to report issues such as light bulbs needing replacement or toilets not functioning. She stated she did not recall reporting any cosmetic issues using the app and had not thought to do so. She stated she had seen previously seen maintenance staff making rounds and doing touch up work and thought they monitored it. She stated she was not aware of the issues in resident's bathrooms. During an interview with the Administrator on 4/25/24 at 4:30 PM, she stated the facility utilized an app to report any issues related to maintenance that were found in the facility and all nursing staff were trained on it's use . A request was made for maintenance logs. In another interview with the Administrator on 4/26/25 at 7:40 AM, she stated daily rounds were conducted by management staff and all issues found were documented on work orders and they had plans in place. The Administrator stated the building was older one and they major projects going on at that time that required the maintenance staff's attention. In an interview on 4/26/24 at 9:48 AM, the DON stated he would expect the nursing staff to report any maintenance or environmental issues. He stated they could log into the maintenance and report anything. The DON stated the risk of having scratch and chipped paint, rotted wood, and rooms in disrepair were that it was not clean and could make the residents feel like no one cared about them. During an interview on 4/26/24 at 10:25 AM, LVN C, 500 Hall Charge Nurse, stated he was aware there were some maintenance issues in the facility as it was an old building. He stated they had an app and were able to enter any issues there and he felt like the maintenance department did a good job at addressing things like lights, bed issues, and plumbing problems very quickly. He stated he had not reported any cosmetic issues recently because he believed there were already work orders placed for them. He stated he frequently saw maintenance staff touching up paint and performing repairs. He stated risks included residents may not feel good about looking at it and the bathrooms could be unsanitary. During an interview and observations with the Maintenance Director on 4/26/24 at 11:23 AM, he explained he had only been at the facility a few weeks. He stated he had a list of items to address but had to start with the high priority items and they had had some major work done on the facility recently. The Maintenance Director stated they utilized an app so that staff could enter any issues they found which would generate a work order. He stated he and his assistant also entered any issues they found while working in the vicinity. When shown the walls in rooms [ROOM NUMBERS], he stated he was aware there were issues like this and they worked to touch-up paint whenever they could. He stated he had asked the CNAs to take care when moving the beds so they were not directly against the walls causing the scratches. When shown the issues in the bathroom shared by rooms [ROOM NUMBERS], the Maintenance Director stated it appeared some plumbing work was done and they still needed to complete the work on the walls. He stated wall repairs were challenging because there was usually sanding involved and that meant coordinating moving a resident from the area because of the dust generated and possible respiratory concerns. When shown the rotted wood and flooring concerns in the bathroom between rooms [ROOM NUMBERS], the Maintenance Director stated he had not previously seen the issues and did not recall being informed about it. The Maintenance Director stated the risks to residents may be concerned for their safety or feel embarrassment if having guests visit. (continued on next page)

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In another interview with the Administrator on 4/26/24 at 2:05 PM, she stated she was aware of the concern areas found during the survey and stated they were working to correct all the issues. She stated they were handling larger life-safety issues first and had lots of items to address. She stated the risks for residents included overall safety from possibly tripping on flooring, hygiene, and cleanliness. She stated residents should feel they were in a comfortable homelike environment. Record review of facility maintenance logs dated 4/26/24 revealed the following entries: Entry dated 4/04/24 at 12:32 PM: Floor in bathroom is coming up. Notes: put floor threshold back, used floor adhesive to secure. Entry dated 4/25/24 at 5:21 PM: room [ROOM NUMBER]. Bathroom flooring needs to be replaced. Entry dated 4/25/24 at 5:16 PM: room [ROOM NUMBER]. Paint touch up needed in the room. Entry dated 4/25/24 at 5:16 PM: room [ROOM NUMBER]: A,B, and bathroom paint needs to be re-painted. Record review of the facility's undated policy titled, Resident Rights provided by the Administrator reflected the following: .Safe environment - The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-1. A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. a. This includes ensuring the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk .2. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior