STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675305	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Valley Healthcare and Rehabilitation Cent	1525 Pleasant Valley Rd Garland, TX 75040

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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 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** 37028 Based on interview and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR) Level I assessment accurately reflected the resident's status for one (Resident #51) of three residents reviewed for PASRR Screenings. 1. The facility failed to ensure the accuracy of the PASRR Level 1 screen for Resident #51. The resident did not receive a PASRR Level II assessment Evaluation. This failure could place residents who had a mental illness at risk of not receiving individualized specialized service to meet their needs. Findings included: Record review of Resident #51's quarterly MDS assessment, dated 03/24/25, reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Section C - Cognitive Patterns was not completed. His diagnoses included stroke, anxiety disorder, depression, and post-traumatic stress disorder (PTSD). Record review of Resident #51's Care Plan reflected: 03/15/24 At risk for re-traumatization related to history of trauma Veteran/PTSD. 03/15/23 At risk for depression. Record review of Resident #51's PASSR level 1 screening, dated 02/22/23, reflected the resident did not have a serious mental illness and serious mental illness was checked as no. Record review of Resident #51's Electronic Health Record revealed no PASSR level 2 evaluation was completed. An interview with the MDS Nurse at 04/24/25 at 4:00 PM revealed Resident #51's PL-1 was incorrect. The MDS Nurse said it was entered into SIMPLE (PASRR electronic documentation system) incorrectly by a previous employee. The MDS Nurse usually checks the PL-1 for accuracy, but did not check Resident #51's. The MDS Nurse said that anyone who had been trained on MDS's was responsible for their accuracy. She said Resident #51 would have been at risk of not receiving appropriate services with an incorrect PL-1. (continued on next page)

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 04/24/25 at 5:38 PM with the DON revealed she did not know if the resident's PL-1 was incorrect. The DON said she would reach out to the coordinator and have them complete an evaluation. An interview on 04/25/25 at 10:20 AM with the PASRR Evaluator for the facility regarding Resident #51 revealed his PL-1 was completed in 2023 and was negative. She said she did another PL-1 evaluation on 04/25/25 and the result was still negative. No PL-2 evaluation was completed. Review of the facility policy, Preadmission Screening and Resident Review, not dated, reflected: Policy: The facility will designate an individual to follow up on ALL residents have received a PASRR Level I screening. If Facility serves a resident with a positive PASRR Level I screening, the facility MUST have obtained A PASRR Level II evaluation from the Local Authority or have a documented attempts to follow up with the Local Authority to obtain the PASRR Level II evaluation .

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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 0684 Level of Harm - Minimal harm or potential for actual harm 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** 37028 Based on observations, interviews, and record reviews, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 (Resident #43) of 3 residents reviewed for quality of care. The facility failed to ensure Resident #43 received treatment immediately after she complained of having symptoms of a urinary tract infection. The resident suffered pain that increased with each shift until treatment was administered. This failure could place residents at risk for a delay in treatment or diagnosis, a decline in the resident's condition, harm and/or the need for hospitalization and prolonged treatment. Findings included: Review of Resident #43's Annual MDS Assessment, dated 03/28/25, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. She had a BIMS score of 15, indicating no cognitive impairment. The resident was occasionally incontinent of bowel and bladder. Her active diagnoses included end stage renal disease (kidney failure) requiring dialysis, heart failure, diabetes, and blindness. Review of Resident #43's Physician Order as of 04/22/25 reflected there were no orders for antibiotics or medications to treat a urinary tract infection. Review of the facility 24-report for 04/22/25 reflected there was no information documented about Resident #43. Review of Resident #43's Facility Medication Administration Record for April 2025 reflected the resident's pain level was 0 every shift and every day for 04/01/25 - 04/21/25. Review of Resident #43's progress notes reflected: Effective Date: 04/22/2025 11:00 AM Type: Nursing Note Text: resident returned from dialysis; assessment performed. Resident is alert and oriented to person, place, and time. Able to make needs known. Denies pain/discomfort. Dressing to left arm dry and intact. Thrill/bruit positive (fistula for dialysis assessment). No bleeding noted. Vitals sign obtained BP 137/78, Pulse 89, Resp 18, 97% oxygen level, Temperature 97.0 degrees farenheit. Call light within reached. no new order received. no concerns voiced. Written by LVN B There were no progress notes regarding Resident #43's complaint of a urinary tract infection. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #43's care plans dated 04/22/25 at unknown time reflected: Resident states she feels like she has a urinary tract infection, and she has low output due to end stage renal disease. Facility interventions included: Give antibiotic therapy as ordered. Monitor/document for side effects and effectiveness. An interview was attempted with Resident #43 on 04/22/25 at 11:26 AM. The resident said she could not talk because she was in the bathroom. An interview was attempted with Resident #43 on 04/22/25 at approximately 12:30 PM. The resident said she could not talk because she was in the bathroom. An interview with Resident #43 on 04/22/25 at 1:51 PM revealed the resident was feeling ill and having pain. The resident said she had a urinary tract infection and kept having to go to the bathroom due to urinary urgency. She said she notified LVN A the evening of 04/21/25 that she had a urinary tract infection. The resident said LVN A told her she was waiting to receive an order from the physician. Resident #43 said she had not received any treatment or medications to treat the urinary tract infection. An interview on 04/22/25 2:04 PM with ADON H revealed there were no orders, progress notes, or documentation on the facility 24-Hour Report to indicate Resident #43 had reported she had a urinary tract infection on 04/21/25 or 04/22/25. ADON H said he would call LVN A to see what happened. ADON H left the front desk. A follow-up interview on 04/22/25 at 2:16 PM revealed ADON H said an order for Macrobid (medication to treat urinary tract infection) was put in at 2:14 PM on 04/22/25. ADON H said it was expected that if a resident reported signs and symptoms of an infection the facility staff would immediately assess and treat. ADON H said the resident was not expected to have to wait. ADON H said the resident's complaint should have been documented on the 24-Hour Report. ADON H said that if a resident was not promptly treated for a UTI, then the resident would be at risk for increased infection and even death. An interview on 04/22/25 at 2:20 PM with LVN A revealed she was assigned to care for Resident #43 on the 2:00 PM - 10:00 PM shift on 04/21/25. LVN A said Resident #43 told her on the evening shift at unknown time on 04/21/25 that she had a UTI. LVN A said she told the physician who told LVN A that he would look at the resident. LVN A said the physician did not give any new orders. LVN A said she did not document a progress note or on the 24-hour report but thought she did. LVN A said the risk to Resident #43 for not receiving treatment was frequent urination, painful urination, and confusion. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 04/22/25 at 3:01 PM with LVN B revealed she saw the Surveyors leave Resident #43's room on 04/22/25 at around 2:00 PM. LVN B said she went in to the resident's room to see what was going on. She said Resident #43 told her she felt funny and had burning pain when urinating. LVN B said she called the Family Nurse Practitioner and received an order for Macrobid and to not wait to get a urine sample. LVN B said the resident had not reported the issue to her on the 6:00 AM - 2:00 PM shift and she was not aware that the resident had complained on 04/21/25. LVN B said the resident had dialysis in the morning of the 6:00 AM - 2:00 PM shift and the next two times, she saw the resident, she was in the bathroom. LVN B said she thought the resident was having diarrhea but had not followed up with the resident. LVN B said she was not notified about the complaint of the resident having a urinary tract infection from the previous shift. LVN B said the resident was at risk for suffering for having to wait to get treatment. An interview on 04/22/25 at 2:25 PM revealed he was the physician for Resident #43 on 04/21/25. The physician said he was notified by LVN A on 04/21/25 that Resident #43 said she had a urinary tract infection. The physician said it was towards the end of the day and he did not go assess or see the resident. The physician said he told LVN A to monitor the resident an obtain a urine analysis. The Physician said Resident #43 would have been at risk for not being seen if the Surveyor had not intervened. The physician said on 04/22/25 he ordered Resident #43 an antibiotic. An interview on 04/23/25 at 10:19 AM with the DON revealed she was told Resident #43 thought she had a urinary tract infection on 04/21/25 and the physician saw her that evening but did not give any orders. The DON said the physician did say to monitor the resident. The DON said early on 04/22/25 LVN B called the physician and discussed whether to do a urine analysis prior to starting Macrobid. The DON said the decision was to go ahead and administer the Macrobid with no urine analysis because the resident was on dialysis and might not be able to give an adequate urine sample. The DON said LVN A did not document a progress note because the doctor did not give her any orders. The DON said the resident was awake, alert, and oriented and able to make her needs known. The DON said she would speak to Resident #43 to make sure she was being cared for and her needs were met. Follow-up interviews on 04/23/25 at 11:37 AM and 12:46 PM with the physician revealed the facility communicated with him by using his call line. He said he was notified by LVN B on 04/22/25 at 2:00 PM regarding Resident #43's complaint of urinary tract infection. The Physician said the issue was a miscommunication and error on his part. He said he gave an order to LVN A on 04/21/25 on the 2:00 PM - 10:00 PM shift to obtain a urine analysis and to monitor the resident, but maybe LVN A did not hear him. The physician said Resident #43 was a minimal risk due to the delay in treatment because there had been no issues with her dialysis or labs prior to 04/21/25. The Physician said the FNP was told about the resident's symptoms on 04/21/25 by him and the FNP was going to see the resident on 04/23/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A follow-up interview on 04/23/25 at 1:03 PM with Resident #43 revealed she was feeling better and able to eat. She said she was not able to eat very much on 04/22/25 because she did not feel well. Resident #43 said her symptoms started on 04/20/25, but she did not report them until 04/21/25. Resident #43 said her pain levels on a scale of 1 (no pain) to 10 (extreme pain) were a 4 on the 2:00 PM - 10:00 PM shift of 04/21/25. The resident said her pain level increased to a 5 on the 10:00 PM - 6:00 AM shift and reached a 6 the morning of 04/22/25. She said the nurse did not ask if she was having pain on any of the shifts. Resident #43 said she did not tell anyone other than LVN A on 04/21/25 during the 2:00 PM - 10:00 PM shift about her pain or urinary tract infection. Resident #43 said she did not tell anyone else about it because she thought LVN A was going to take care of it. Resident #43 said she did not receive any pain medication 04/21/25 - 04/23/25. Review of the facility policy, Quality of Care: Significant Change in Condition, Response, revised December 2023, reflected: Policy It is the policy of this facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical mental and psychosocial well-being in accordance with the interdisciplinary comprehensive assessment and plan of care . Change in output (bowel or bladder) including amount, color, consistency, odor, or frequency. 2. The nurse will perform and document an assessment of the resident and identify need for additional interventions, considering implementation of existing orders or nursing interventions or through communication with the resident's provider using SBAR or similar process to obtain new orders or interventions. 3. The resident will then be placed on the 24-Hour Report and Nursing will provide no less than three (3) days of observation, documentation, and response to any interventions. An attempt to identify the cause for decline, when it occurs, needed assist and resident behavior/ acceptance of increased need of assistance will be monitored . 4. The nurse will communicate the change to other departments as appropriate and updated communications will be available during morning report. 5. There will be certain circumstances where immediate attention will be warranted and nursing will be responsible for notifying the appropriate department for evaluation. The nurse shall use his/ her clinical judgment and shall contact the physician based on the urgency of the situation. The Medical Director shall be notified in the event that the Attending Physician or on-call Physician cannot be reached. The resident/ resident representative will be notified of the change of condition and any changes in the resident's medical or nursing care. 6. Each department notified will perform their own evaluation and assessment to determine if the change requires further intervention and implement actions accordingly. The nurse will transcribe the treatment and plan of care relative to the change of condition on the resident Electronic Medical Record (EMR).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 (Resident #22) of 1 resident reviewed for incontinence care. 1. The facility failed to ensure CNA N did not double-brief Resident #22. 2. The facility failed to ensure CNA O thoroughly cleaned the vaginal area of Resident #22. This failure placed residents at risk for the development and/or worsening of urinary tract infections. Findings included: Record review of Resident #22's MDS quarterly assessment dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included heart failure, kidney failure, diabetes, stroke, and Alzheimer's disease. She had a BIMS score of 6 which indicated moderate cognitive impairment. The resident was dependent on staff for toileting. The resident was always incontinent of bowel and bladder. Record review of Resident #22's care plan, dated 08/14/24, reflected: The resident had bowel/bladder incontinence related to dementia, impaired mobility, and overactive disorder. Facility interventions included uses disposable briefs. Change as needed. Check as required for incontinence. Wash, rinse and dry perineum. An observation of incontinence care and a transfer for Resident #22 on 04/23/25 at 3:12 PM revealed CNA O and CNA P were preparing to do incontinence care and a transfer. Both CNAs washed their hands and donned (put on) gloves. The resident was transferred to bed. The resident was soaked with urine. It went through her clothes and onto the towel in the wheelchair. Both CNAs said they did not know when the resident was last changed for incontinence care. CNA O said the resident was usually soaked when he changed her after coming on the 2:00 PM shift. CNA P removed the resident pants. CNA O opened the brief, and it was revealed that the resident was wearing two briefs and both briefs were soaked. CNA O prepared to clean the resident. He cleaned the peri-area but did not open the resident's labia major and labia minor to cleanse the resident. CNA O and CNA P finished cleaning the resident and put on a clean brief. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 04/24/25 at 6:18 PM with CNA O revealed he had been trained to perform incontinence care. He said he was checked off on 04/23/25 after changing Resident #22 and in January 2025 for incontinence care. He said he did not thoroughly cleanse the resident's vaginal area because he was nervous. He said if he did not thoroughly cleanse the resident then she could develop an infection, wounds, and itchiness. He said he did not know why the resident was double-briefed. He said he changed the resident every 2 hours on his shift. An interview on 04/25/25 at 10:06 AM with CNA N revealed she was assigned to care for Resident #22 on the 6:00 AM - 2:00 PM shift for 04/23/25. She said she was supposed to check and change the resident every 2 hours, but on 04/23/25 she only changed her twice. CNA N said she knew she was not supposed to double-brief the resident, but she was in a hurry. CNA N said she had never double briefed a resident before. She said double briefing a resident and not checking and changing her every 2 hours could cause breakdown, bed sores, and urinary tract infections. An interview with the DON on 04/24/25 at around 5:00 PM revealed CNAs were trained on how to perform incontinence care and received competency checks. The DON said annual training and as needed training was completed with CNAs. The DON said the resident should never be double-briefed and residents should be checked for timely incontinence care. The DON said the resident was at risk for skin breakdown and infection. Review of the facility's policy, Incontinent Care, revised May 2024, reflected: POLICY: It is the policy of this facility to: 1. Ensure residents are clean 2. Cleanse and lubricate skin as needed. PROCEDURES: Equipment: o Disposable incontinent brief, pad or resident's own undergarment (as a plan of care) o Linen, as needed o Washcloth or wipes as required. o Soap, peri wash or wipes. o Lotion or barrier cream as ordered. 1. Assemble equipment. Explain procedure. Provide privacy by closing door and securing privacy curtain. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Assist resident to lay in bed, explain procedure to resident. Clean from front to back, clean hands, change gloves, clean the back going upwards. 3. Clean hands and Donn gloves and apply brief. 4. Apply lotion or barrier cream as ordered. 5. Check for incontinence at least every two (2) hours.

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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. 47030 Based on observations, interviews, and record review, the facility failed to, store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen safety. Facility failed to utilize proper personal hygiene practices (e.g., proper hand washing and the appropriate use of gloves) to prevent contamination of food. These failures could place 77 residents who reside at the facility and eat meals prepared and served by the facility's kitchen at risk of contracting a foodborne illness. Findings Included: Observations during follow up visits to the kitchen on 4/24/25 beginning at 11:30am included the following: Cook Q left the prep area with gloves on and put trash in the recycle can then returned to prep and continued to prepare the food with the same gloves. Interview on 4/25/25 at 1:30pm with [NAME] Q revealed gloves are changed each time touch something different like touching trash can. [NAME] Q revealed important to change gloves when touching things other than the food because residents could become sick. Interview on 4/23/25 at 11:30am with The Dietary Manager. The Dietary Manager revealed he has worked at the facility since 2022. The Dietary manager revealed if sick not to come to work and if gets sick at work notify Administrator as his supervisor and if it is his staff they report to him/the The Dietary manager. Interview on 4/23/25 at 11:30am the The Dietitian revealed she was in the facility 3x per month with duties of oversee the Dietary Manager, monitor clinical issues, complete dietary assessments with all residents, monitor for weight loss, and oversee the therapeutic diets for each resident. Interview on 4/24/25 at 1:30pm with Dietary Aide R revealed he was new to the facility. Dietary Aide R revealed if he was sick at home at a time, he was scheduled to work Dietary Aide R would call his manager. Dietary Aide R revealed if he was at work and became sick, he would notify his manager and go home. Dietary Aide R revealed gloves are wore to not spread contamination. Dietary Aide R revealed one of the reasons to change gloves would be if the glove ripped, he would need to change his gloves. Review of the facility's Hand Hygiene Policy and Procedure dated: Original date: 5/2007 Revision/Review Date(s): 6.2021, 1.2022,10.2022 Reflected: Purpose (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hand hygiene is one of the most effective measures to prevent the spread of infection. Studies show that effective hand decontamination can significantly reduce the rate of healthcare associated infection. All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors. Residents, family members and/or visitors will be encouraged to practice hand hygiene through the use of fact sheets, pamphlets and/or other written materials provided at the time of admission and/or posted throughout the facility. Definitions Hand hygiene is a general term that applies to hand washing, antiseptic hand wash, and alcohol-based hand rub. Hand washing is the vigorous, brief rubbing together of all surfaces of hands with soap and water, followed by rinsing under a stream of water. Alcohol-based hand rub (ABHR) is a 60-95 percent ethanol or isopropyl alcohol-containing preparation base designed for application to the hands to reduce the number of viable microorganisms. Procedure 1. Wash hands with soap and water for the following situations: a. When hands are visibly soiled (e.g., blood, body fluids) b. After caring for a resident with known or suspected Clostridioides (C.) Difficile or Norovirus infection during an outbreak, or if infection rates of C. Difficile Infection (CDI) are high 2. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after coming on duty; b. Before and after direct contact with residents; c. Before preparing or handling medications; d. Before performing any non-surgical invasive procedures; e. Before and after handling an invasive device (e.g., urinary catheters, IV access sites); f. Before donning sterile gloves; g. Before handling clean or soiled dressings, gauze pads, etc.; (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin; j. After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc.; l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; m. After removing gloves; n. Before and after entering isolation precaution settings; o. Before and after eating or handling food; p. Before and after assisting a resident with meals; and q. After personal use of the toilet or conducting your personal hygiene. r. After removing and disposing of personal protective equipment.