| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675809 | A. Building<br>B. Wing | 09/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westridge Nursing and Rehabilitation | 1241 Westridge Ave<br>Lancaster, TX 75146 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222<br><br>Based on observations, interviews, and record reviews, the facility failed to exercise reasonable care for the protection of the resident's property from loss or theft for 2 (Resident #13 and Resident #87) of 6 residents reviewed for resident rights.<br><br>The facility failed to protect Resident #13's (2 pairs of Dickies pants, 3 pairs of Dickies coveralls, socks, and gray pant suit) and Resident #87's (2 pairs of shoes, a jacket, and a pair of shorts) clothes from being lost.<br><br>This deficient practice could place residents receiving laundry services at risk of negatively impacting their quality of life and at risk for low self-esteem.<br><br>Findings Included:<br><br>1. Record review of Resident #13's face sheet dated 9/18/24 revealed Resident #13 was [AGE] years old and was admitted to the facility on [DATE] with diagnoses of depression and mild intellectual disabilities.<br><br>Record review of Resident #13's OSA MDS assessment dated [DATE] revealed a BIMS score of 10 (suggested resident's cognition was moderately impaired) and a diagnosis of diabetes.<br><br>Record review of Resident #13's care plan updated on 9/10/24 revealed Resident #13 had impaired speech with a goal for the resident's needs or wants to be met at all times and revealed Resident #13 required assistance with dressing.<br><br>Record review of Resident #13's admission packet, with a resident signature date of 1/02/24, on page 5 in section B stated, The Center shall make reasonable efforts to safeguard the Resident's property/valuables that the Resident chooses to keep in his or her possession and page 46 under resident rights stated, The Resident has a right to retain and use personal possessions, including some furnishings and appropriate clothing. The admission packet also revealed in attachment G on pages 48 and 49 You have a right .14) to keep and use personal property, secure from theft or loss.<br><br>Resident #13 was not in the facility on 9/17/24 or 9/18/24 for interview or observation and attempts during that time to contact the family were unsuccessful.<br><br>(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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675809 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/18/2024 |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an observation on 9/17/24 at 12:52 p.m., Resident #13's closet was empty except for 1 T-shirt with no name.<br><br>2. Record review of Resident #87's quarterly MDS dated [DATE] revealed Resident #87 was [AGE] years old, admitted on [DATE] with diagnoses of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and dementia (memory loss), and a BIMS score of 8 (suggested resident's cognition was moderately impaired).<br><br>Record review of Resident #87's care plan stated that resident should have proper fitting and appropriate foot attire.<br><br>In an observation on 9/18/24 at 11:17 a.m., inside Resident #87's closet was 1 shirt with his name, 3 pairs of pants without a name, and 4 shirts without a name.<br><br>Resident #87's admission packet was not available for record review.<br><br>Record review of grievances dated 8/6/24 revealed a complaint made by the family of Resident #13 that stated Resident #13 was missing 2 pairs of pants, 3 overalls, 1 sweat pant suit, and 6 pairs of socks. The follow up section for the grievance was blank. There was no grievance log for August that showed any response to the grievance.<br><br>In an interview on 9/17/24 at 10:18 a.m., Housekeeper A stated she did laundry 3 days a week and the laundry aide did laundry the rest of the week. She stated the residents' names were written inside of their clothes, so staff would know who they belonged to. Housekeeper A stated if the clothing did not have a name, then it would be hung up in the laundry room until it was claimed. Housekeeper A stated sometimes clothes were put in the wrong room, but then they were removed and given to the right resident.<br><br>In an interview on 9/17/24 at 12:54 p.m., Laundry Aide A stated she found maybe 4 pairs of coveralls that morning that belonged to Resident #13. Laundry Aide A stated the Lead Housekeeper gave her a list of missing clothing, so she started looking for them that morning. Laundry Aide A stated they were found in a closet in room [ROOM NUMBER] and that there was not a name on the clothing found but it matched the list.<br><br>In an interview on 9/17/24 at 1:39 p.m., the Lead Housekeeper stated 3 pairs of Dickies coveralls and 2 pairs of Dickies pants that belonged to Resident #13 had been found that day. The Lead Housekeeper stated they did not find any sweatpants or socks, and she had just received a list of the missing items on 9/15/24. The Lead Housekeeper reported that there were no names on the clothes, and Resident #13's family was upset that the clothes were missing. The Lead Housekeeper reported the clothes were taken to the ADM's office.<br><br>In an observation on 9/17/24 at 1:42 p.m., a black trash bag in the ADM's office contained 3 pairs of Dickies coveralls and 2 pairs of Dickies pants. No labels or names were on the clothing.<br><br>In an interview on 9/17/24 at 2:20 p.m., CNA D stated sometimes the laundry aide would put the clothes in the wrong closet. CNA D also stated the laundry had been put in random rooms and had to be returned to the laundry room or to the correct resident. CNA D stated sometimes the residents got mad and complained that they are missing clothes.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 9/17/24 at 2:30 p.m., CNA E reported sometimes the housekeeper would put the clothes in the wrong place, and CNA E would have to take them to the right spot. CNA E stated the resident's family sometimes would put the names in the clothing and sometimes the nursing staff did, so they knew who the clothes belonged to.<br><br>In an interview on 9/17/24 at 3:19 p.m., the Housekeeping Team Leader stated the laundry aide was responsible for putting clothes up in the right spot. The Housekeeping Team Leader also stated if there was no name on the clothes, they could belong to anyone. The Housekeeping Team Leader stated it was never the duty of the laundry aide or housekeepers to label the clothing.<br><br>In an interview on 9/17/24 at 3:35 p.m., the DON stated that residents should have their names on their clothes. The DON stated the nursing staff should have ensured names were in the clothes and put a name if it was missing.<br><br>In an interview on 9/18/24 at 11:03 a.m., LVN F stated nurses or CNAs should label clothing upon admission and the laundry aide was responsible for returning the clothes to the residents. LVN F stated if a resident's clothes were missing, the residents could become upset.<br><br>In an interview on 9/18/24 at 11:25 a.m., Laundry Aide A stated Resident #13's clothes had been missing for maybe a month, and she just thought to check the closet in room [ROOM NUMBER] on 9/17/24. Laundry Aide A stated that sometimes CNAs put extra clothes in that closet because it had extra room in it.<br><br>In an interview on 9/18/24 at 11:36 a.m., Resident #87 reported he was still missing 2 pairs of shoes, a jacket, and a pair of shorts. When asked how this made him feel, Resident #87 stated he would like to have his clothes.<br><br>In an interview on 9/18/24 at 11:48 a.m., the DON stated they became aware of Resident #87's missing clothes 2 weeks ago and that some of the clothes had been found in other resident's rooms. The DON stated the family had labeled all of Resident #87's clothing with a marker. The DON stated the charge nurses should ensure clothing was labeled by the CNAs and the risk to the residents was that their clothes could be misplaced or lost.<br><br>In an interview on 9/18/24 at 1:17 p.m., the ADM stated she was not aware of the grievance for Resident #13 from 8/6/24 until 9/17/24. The ADM stated the interim ADM did not complete a grievance log for August. The ADM reported that she was responsible for reviewing the grievances until a full-time social worker could be hired. The ADM stated the laundry aides were expected to deliver clothes to the residents' rooms and the nursing staff was expected to write the residents' names in the clothes. The ADM stated the clothing was labeled so that staff would know who the clothes belonged to. The ADM did not state how this could affect the residents.<br><br>In an interview on 9/18/24 at 1:46 p.m., a family member for Resident #87 stated they had replaced Resident #87's clothing 3 times in 5 months. The family reported when they came to visit on 8/27/24, Resident #87 was wandering down the hall wearing a hospital gown and no underwear. The family member stated that it definitely bothered Resident #87 to not have his clothes. The family member also stated they had bought the resident new clothes that included a jacket and 2 pairs of shoes.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility policy titled Admitting the Resident: Role of the Nursing Assistant, with a revision date of February 2022, revealed Steps in the Procedure . 11. Write the resident's name on appropriate articles (i.e. , water pitcher, cup, urinal, denture cup, etc.).<br><br>Review of the facility policy titled Personal Property, with a revision date of March 2021, revealed Residents are permitted to retain and use personal possessions, including furniture and clothing, and 3. Residents are encouraged to use personal belongings to maintain a homelike environment and foster independence. |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50222<br><br>Based on interviews and record reviews, the facility failed to resolve grievances for 1 (Resident #13) of 10 residents reviewed for resident rights.<br><br>The facility did not document efforts to resolve a grievance expressed by Resident #13's responsible party that stated Resident #13 was missing 2 pairs of pants, 3 overalls, 1 sweat pant suit, and 6 pairs of socks<br><br>This failure could place residents at risk for feelings of worthlessness and for not receiving adequate care and services.<br><br>Findings Included:<br><br>Record review of Resident #13's face sheet dated 9/18/24 revealed Resident #13 was [AGE] years old and was admitted to the facility on [DATE] with diagnoses of depression and mild intellectual disabilities.<br><br>Record review of Resident #13's OSA MDS assessment dated [DATE] revealed a BIMS score of 10 (suggested resident's cognition was moderately impaired) and a diagnosis of diabetes.<br><br>Record review of Resident #13's care plan updated on 9/10/24 revealed Resident #13 has impaired speech with a goal for the resident's needs or wants to be met at all times and revealed Resident #13 required assistance with dressing.<br><br>Record review of Resident #13's admission packet, with a resident signature date of 1/02/24, on page 45 under Resident Rights stated, The resident has a right to prompt efforts by the Center to resolve grievances.<br><br>Record review of grievances dated 8/6/24 revealed a complaint made by the family of Resident #13 that stated Resident #13 was missing 2 pairs of pants, 3 overalls, 1 sweat pant suit, and 6 pairs of socks. The follow up section for the grievance was blank. There was not a grievance log for August that showed any response to the grievance.<br><br>Resident #13 was not in the facility on 9/17/24 or 9/18/24 for interview or observation and attempts during that time to contact the family were unsuccessful.<br><br>In an interview on 9/17/24 at 2:13 p.m., the ADM stated she was unable to answer how often the grievances were reviewed because she had just started working in the building 2 weeks ago. The ADM stated grievances needed to be addressed within 5 days and that she was going to follow up with the grievance concerning Resident #13 that day.<br><br>(continued on next page) |

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| F 0585<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 9/18/24 at 1:17 p.m., the ADM stated she was not aware of the grievance for Resident #13 from 8/6/24 until 9/17/24 but had found some of Resident #13's clothes on 9/17/24. The ADM reported she contacted a family member of Resident #13 the previous day concerning the grievance, but had not contacted the family member that filed the grievance yet. The ADM stated the interim ADM did not complete a grievance log for August. The ADM reported that she was responsible for reviewing the grievances until a full-time social worker could be hired. The ADM stated the grievances should be reviewed so they could take care of any issues or concerns the residents or families had. The ADM did not state the effect this could have on the resident.<br><br>Review of the facility policy titled Grievances, Recording and Investigating, with a revision date of 1/12/23, revealed 5. The Resident Grievance Form will be filed with the Administrator or designee and the resolution will be identified within three (3) working days of the concern. |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44021<br><br>Based on record reviews, and interviews, the facility failed to ensure a resident's environment remained free of accidents or hazards and received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (Resident #22) reviewed for transfers in that:<br><br>1. The facility failed to ensure CNA O provided adequate supervision and transfer assistance for Resident #22 attempting to conduct a transfer without assistance or without an assistive device.<br><br>2. The facility failed to ensure that CNAs were knowledgeable about locating the resident's safe transfer status requirements for Resident #22.<br><br>An immediate jeopardy existed from [DATE] - [DATE]. The IJ was determined to be at past noncompliance as the facility had implemented actions that corrected the noncompliance prior to the beginning of the investigation.<br><br>This deficient practice placed residents at risk for falls, injuries, and hospitalization .<br><br>Findings included:<br><br>Review of Resident #22's Face sheet dated [DATE] reflected a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnosis that included Cerebral Infarction (stroke), Displaced fracture of the greater tuberosity of right humerus (fracture of the neck of the upper arm bone that did not break the skin), Pain, Muscle wasting and atrophy left thigh and left lower extremity, Adult failure to thrive, Hemiplegia and hemiparesis following Cerebral Infarction (paralyzation following a stroke).<br><br>Review of Resident #22's Minimum Data Set (MDS) assessment dated [DATE] reflected in section GG titled Functional Abilities and Goals Resident #22 had limited range of motion and impairment on both sides of her body and required the use of a wheelchair. Resident #22 required substantial/maximal assistance to totally dependent in the following areas: Toileting hygiene, Shower/bathe, lower body dressing, and putting on/taking off footwear. Resident #22 required total dependent assistance (or the assistance of 2 or more helpers) to roll left or right, sit to lying, lying to sitting on edge of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer.<br><br>Review of Resident #22's Care Plan dated [DATE] reflected Problem/Category: ADL's Functional Status/Rehabilitation Potential Resident #22 had self-care deficits and is at risk for a decline in ADL function related to physical impairments due to Cerebral Vascular Accident with HP and UE Fx. Resident #22 may require more assistance some days more than others. Approach: Transfers: mechanical lift (2 person assist). Further review of Resident #22's care plan revealed a newer entry dated [DATE] regarding transfers . Problem/Category: ADL's Functional Status/Rehabilitation Potential [Resident #22] is unable to use mechanical lift sling with transfer. Requires 6 staff members to transfer using sheet to wheelchair from bed . Approach: Transfer to w/c using sheet with 6 staff for assistance.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the Incident Accident report dated [DATE] to [DATE] Revealed Resident #22 suffered a fracture on [DATE] as the result of an improper transfer.<br><br>Record Review of a written statement dated [DATE] signed and dated by CNA O and RN S reflected that . [CNA O] entered [Resident #22's] room and began to transfer Resident #22. CNA O sat resident #22 on the side of the bed, wrapped arms around the resident, began to move from bed to wheelchair. Resident #22's chair began to move slightly backwards, CNA O began to lower Resident #22 and braced her with knee, when she heard a pop. Resident #22 was positioned in wheelchair and charge nurse [LVN P] was notified. CNA O states she was not assigned to that hallway and was unaware Resident #22 was a Hoyer lift.<br><br>Review of Resident #22's nursing progress notes revealed that CNA O reported to LVN P that she had heard a pop when transferring Resident #22 from the resident's bed to the resident's wheelchair. LVN P and the RN S assessed the resident and notified the MD and ordered an x-ray. The x-ray revealed a displaced closed fracture of Resident #22's right humerus.<br><br>An attempt at an interview on [DATE] at 11:00 AM revealed that CNA O's listed contact phone number was disconnected.<br><br>In an interview and observation on [DATE] at 11:12 AM Resident #23 was observed being transferred via a mechanical lift. CNA K and CNA L were observed to apply mechanical lift sling to the supine resident for transfer from bed to wheelchair. Bed put in lowest pos, resident raised without incident by both staff members. Resident appeared to tolerate transfer well no signs of pain or mental duress. Resident stated she had never had a problem with being transferred by the mechanical lift, being lifted was scary the first couple of times but now she stated she was used to being lifted. She stated that she felt safe at the facility and had no complaints regarding her care or treatment at the facility.<br><br>In an interview and observation on [DATE] at 1:08 PM Resident #24 was observed being transferred via a mechanical lift device from her wheelchair to her bed. CNA M and CNA L were observed performing the transfer. Sling placed on resident, bed to lowest pos, resident legs kept closed by CNA during transfer and steadying/guiding Resident #24 to the bed while the other CNA lifted and pushed the machine. Resident observed to have tolerated the transfer well. No signs of pain or mental duress. Resident stated she had been lifted many times at the facility and had never felt in danger, the CNA's knew how to do it. She stated she had no complaints about her care or treatment at the facility.<br><br>In an interview and observation on [DATE] at 3:01 PM Resisdent #25 was observed being assisted with with a transfer by CNA N. Resident# 25 was able to assist with her transfer with assistance from CNA N. Resident's wheel chair was set with brake engaged next to bed. Resident #25's bed was observed to be lowered to level of wheel chair, resident assisted to edge of bed and steadied by CNA N, resident was able to stand with assistance and guided to a seated posistion in wheel chair without incident. Resident #25 stated that the staff knew her routine well and assisted her many times without incident to her wheel chair and back to bed. She stated that she had no complaints about her care or treatment at the facility.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on [DATE] at 4:19 PM the Regional RN stated that all of the CNAs had had access to resident profiles that listed if a resident is mechanical lift, two person assist, or minimal assist. The Regional RN new CNAs were trained during orientation training to have ben able to access resident profiles to see what level of assistance residents required. The Regional RN stated that the the Former Administrator had been in charge at the time of the incident and the current Administrator had been at he facility for only 6 days. The incident had occurred nearly a month before the current Administrator came to the facility.<br><br>In an interview on [DATE] at 4:24 PM, the DON stated that CNA O had been immediately suspended during the investigation, did not return to the facility or answer any phone calls from the facility, and had been terminated that evening.<br><br>Review of CNA O's personnel file revealed that CNA O started work at the facility on [DATE], and was terminated as a result of the transfer incident on [DATE]. No other incidents or complaints were discovered in her employee file.<br><br>In an interview on [DATE] at 11:24 AM, LVN P stated that CNA Q, the CNA that was on that hall the evening that CNA O had the incident with Resident #22 and had asked CNA O to help assist with changing Resident #22. He stated that CNA O had come and reported to him that she had heard a pop while transferring Resident #22. He stated that he and RN S had then gone and immediately assessed Resident #22. He stated that mechanical lift residents were posted behind he nurses stations and that CNA's had access to resident profiles in the facility computer system<br><br>An interview on [DATE] at 11:27 AM with CNA Q revealed she had been the CNA on Resident #22's hallway that day and that Resident #22 requested to be changed by a different aide, so she had asked CNA O to come and assist her with changing Resident #22. Resident #22 must had indicated to CNA O that she wanted to be transferred to her wheelchair before she had been able to get to Resident #22's room. She stated that CNA O was just supposed to start setting up the equipment needed to change and clean Resident #22. She stated that Resident #22 had been a Hoyer lift for a long time and that there were lists of residents that required Hoyer lifts posted behind every nurse station. She further stated, after the incident, all of the staff had been trained on Hoyer lifts, where to look up resident profiles, she had been observed performing Hoyer lifts and other transfers, and she had taken and passed a competency test.<br><br>Review of sign in sheets for the following in-service trainings between the dates of [DATE] to [DATE] revealed that 89 staff involved in patient care were in serviced on the following topics: Proper Hoyer Lift Procedure, Abuse and Neglect, Pain, Hoyer Transfers and Safety, Gait Belt Use, How to Access Transfer Code Care Assist and Care for Resident #22's Arm Sling.<br><br>Review of Observation/Competency Checks for Hoyer Lifts Procedures, Transfer Safety, Accessing Patient Care Profiles, revealed 89 staff members involved in patient care were tested and observed for all for the above competencies. All Competency tests/observations were signed by the ADM, DON, ADON and Regional Nurse. The results showed that staff had been retrained successfully.<br><br>Review of Safe Surveys of 52 residents, representing the entire resident population dated [DATE] to [DATE] Entitled Transfer Safety found no negative findings about transfers from the residents.<br><br>(continued on next page) |

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|---|---|
| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interviews were conducted with 8 RNs, 11 CNAs, and 1 MA were conducted on [DATE]. All staff interviewed were able to recount all In-Service topics, stated that they had a pre-test before the in-services and after the in-services. All interviewed staff stated that they had been observed conducting Hoyer and other transfers while being observed by the Regional RN, DON or ADON. All staff were able to identify where and how to access residents' profile information.<br><br>Review of the facility Safe Resident Handling/ Transfers policy last revised ,d+[DATE] revealed:<br><br>.It is the policy of this community to ensure that patients/residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the patient/resident while keeping the team members safe in accordance with current standards and guidelines .<br><br>- All patients/residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the team members that assist them. The use of mechanical lifts is a safer alternative to manual lifting for patients, residents, and caregivers .<br><br>Compliance Guidelines:<br><br>- The interdisciplinary team or designee will evaluate and assess individual mobility needs, considering other factors as well, such as weight and cognitive status .<br><br>- The mobility needs will be addressed on admission and reviewed quarterly, after a significant change in condition or based on direct care staff observations or recommendations .<br><br>- Team members will be educated on the use of safe handling/transfer practices to include use of mechanical lift devices upon hire, annually and as the need arises or changes in equipment occur .<br><br>- Team members are expected to maintain compliance with safe handling/transfer practices. Failure to maintain compliance may lead to disciplinary action up to and including termination of employment .<br><br>- Lifting and transferring will be performed according to the individualized plan of care |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675809 | A. Building<br>B. Wing | 09/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westridge Nursing and Rehabilitation | 1241 Westridge Ave<br>Lancaster, TX 75146 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|

F 0842

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

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** 50222

Based on interviews, and record reviews, the facility failed to ensure resident medical records were complete and accurately documented according to accepted professional standards and practices for 1 (Resident #13) of 6 residents reviewed for medical records.

The facility failed to complete Resident #13's inventory form.

This failure could place residents at risk of negatively impacting their quality of life due to the loss of personal items.

Findings Included:

Record review of Resident #13's face sheet dated 9/18/24 revealed Resident #13 was [AGE] years old and was admitted to the facility on [DATE] with diagnoses of depression and mild intellectual disabilities.

Record review of Resident #13's OSA MDS assessment dated [DATE] revealed a BIMS score of 10 (suggested resident's cognition was moderately impaired) and a diagnosis of diabetes.

Record review of Resident #13's care plan updated on 9/10/24 revealed Resident #13 has impaired speech with a goal for the resident's needs or wants to be met at all times and revealed Resident #13 requires assistance with dressing.

On 9/17/24 at 2:48 p.m., no inventory form was found in Resident #13's EMR.

In an interview on 9/17/24 at 3:08 p.m., LVN H stated the inventory form was completed by the nurse upon admission of new residents and was located in the EMR. LVN H stated the inventory form was not updated after admission and that this form was a mandatory form on all admissions.

In an interview on 9/17/24 at 3:28 p.m., the ADON stated that the resident's inventory was documented upon admission, and the inventory form should be updated with any clothes brought after the admission. The ADON stated she was unable to locate the inventory list for Resident #13.

In an interview on 9/17/24 at 3:35 p.m., the DON reported that an inventory sheet should be completed when a resident was admitted and when new things were brought to the resident.

In an interview on 9/17/24 at 3:58 p.m., the DON reported she was unable to locate an inventory sheet for Resident #13 and that the nurses were expected to complete an inventory sheet for every resident.

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675809 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/18/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Westridge Nursing and Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 1241 Westridge Ave Lancaster, TX 75146 | |

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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In an interview on 9/18/24 at 11:09 a.m., LVN F stated an inventory was done with all new admissions and it would be updated if clothes were brought at a later date. LVN F stated that the CNA documented the resident's belongings on a piece of paper, and the nurse documented the information from the CNA's paper in the EMR. LVN F stated it was the nurse's responsibility to ensure the CNAs performed this duty. LVN F stated the inventory form was completed, so they knew what clothes the resident had. LVN F also stated that residents may become upset if their clothes were lost.<br><br>In an interview on 9/18/24 at 11:48 a.m., the DON stated that the charge nurse should ensure the inventory list was done and clothes were labeled. The DON stated the risk to the residents was that their clothes could be misplaced or lost.<br><br>Review of the facility policy titled Admitting the Resident: Role of the Nursing Assistant, with a revision date of February 2022, revealed Steps in the Procedure . 14. Assist with Inventorying the Resident's Personal Effects. |