STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675840	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arden Place of Richland Hills	7146 Baker Blvd Richland Hills, TX 76118

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on interview and record review the facility failed to immediately notify, consistent with his or her authority, the resident representative(s) when there was a significant change in the resident's physical, mental, or psychosocial status for 1 (Resident #2) of 5 residents reviewed for notification of changes. The facility failed to notify Resident #2's designated emergency contact [Family Member] when he developed altered mental status and sustained a head injury while nearly falling out of bed. This failure could place residents at risk of their responsible parties not being notified or involved in their plan of care. Findings included: Record review of Resident #2's Admission Record dated [DATE] revealed he was a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE]. Under Contacts, Resident #2 was listed as being his own responsible party and the name and phone number Resident #2's Family Member was included as his additional contact. Record review of Resident #2's Significant Change MDS assessment dated [DATE] revealed he had diagnoses including anemia (lack of enough red blood cells needed to carry oxygen throughout the body), orthostatic hypotension (low blood pressure that happens when sitting or lying down that can cause dizziness), cirrhosis (liver damage), anxiety, depression, and chronic obstructive pulmonary disease (lung disease that can make breathing difficult). He had clear speech, he was usually understood and could usually understand others. He had a BIMS score of 11 indicating he had moderately impaired cognition. The MDS reflected it was very important for him to have his family or close friend involved in discussions about his care and he required substantial/maximum assistance to transfer from his bed to a chair. The MDS reflected he was almost constantly in pain that frequently made it hard to sleep and he had sustained one fall since readmission with no injury. He was receiving hospice care while a resident. Record review of resident #2's Care Plans revealed an entry dated initiated [DATE] that reflected, [Resident #2] has had an actual fall r/t Unsteady gait [DATE]. Interventions/Tasks included checking range of motion and providing activities that promote exercise and strength building where possible. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were no facility care plans related to any other incidents or his hospice care. Record review of Resident #2's Physician's orders revealed an entry dated [DATE] which reflected, admitted to [hospice company name] Hospice diagnosis of [COPD] . Record review of Resident #2's Progress Notes reflected the following nursing entries for [DATE]: [DATE] 11:57 AM: Skin Only Evaluation. Skin: Skin warm & dry, skin color WNL and turgor is normal. Resident does not have an external device. Signed by the DON. [DATE] 10:21 PM: Resident refused medications this shift. Signed by LVN V. [DATE] 7:51 AM LATE ENTRY Situation: The Change In Condition/s reported on this CIC Evaluation are/were: Abnormal vital signs (low/high BP, heart rate, respiratory rate, weight change) Seems different than usual At the time of evaluation resident/patient vital signs, weight and blood sugar were: - Blood Pressure: BP ,d+[DATE] - [DATE] 07:53 Position: Lying r/arm - Pulse: P 68 - [DATE] 07:54 Pulse Type: Irregular - new onset - RR: R 26 - [DATE] 07:54 - Temp: T 97.1 - [DATE] 07:55 Route: Tympanic - Weight: W 130.0 lb -[DATE] 09:36 Scale: Wheelchair - Pulse Oximetry: O2 81 % - [DATE] 07:55 Method: Oxygen via Nasal Cannula - Blood Glucose: Resident/Patient is in the facility for: Long Term Care Primary Diagnosis is: K74.60 UNSPECIFIED CIRRHOSIS OF LIVER E44.0 MODERATE PROTEIN-CALORIE MALNUTRITION F32.A DEPRESSION, UNSPECIFIED D64.9 ANEMIA, UNSPECIFIED K59.00 CONSTIPATION, UNSPECIFIED F41.9 ANXIETY DISORDER, UNSPECIFIED G89.4 CHRONIC PAIN SYNDROME (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	M87.059 IDIOPATHIC ASEPTIC NECROSIS OF UNSPECIFIED FEMUR B18.2 CHRONIC VIRAL HEPATITIS C F51.05 INSOMNIA DUE TO OTHER MENTAL DISORDER Z79.891 LONG TERM (CURRENT) USE OF OPIATE ANALGESIC J18.9 PNEUMONIA, UNSPECIFIED ORGANISM R53.1 WEAKNESS R29.6 REPEATED FALLS J44.9 CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED I95.89 OTHER HYPOTENSION Relevant medical history is: COPD Code Status: DNR Advance directives are: Resident/Patient had the following medications changes in the past week: Resident/Patient is on Coumadin/warfarin [blood thinners]: No The result of last INR: Date: Resident/Patient is on anticoagulant [blood thinner] other than warfarin: No Resident/Patient is on: Outcomes of Physical Assessment : Positive findings reported on the resident/patient evaluation for this change in condition were: - Mental Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) - Functional Status Evaluation: Needs more assistance with ADLs - Behavioral Status Evaluation: - Respiratory Status Evaluation: - Cardiovascular Status Evaluation: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Abdominal/GI Status Evaluation: No changes observed - GU/Urine Status Evaluation: No changes observed - Skin Status Evaluation: No changes observed - Pain Status Evaluation: Does the resident/patient have pain? Yes - Neurological Status Evaluation: No changes observed Nursing observations, evaluation, and recommendations are: Generalized weakness, gasping for air, refused to eat or drink. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: [name of hospice] HOSPICE B. New Testing Orders: [blank] C. New Intervention Orders: [blank]-- Comments: [blank] Signed by LVN Q and the DON. [DATE] 4:27 PM: V/S assessed ,d+[DATE],68,16,97.8, 96% O2 @ 2 via n/c, resident not responding when called by his name, and unable to eat or drink. [name of hospice] hospice contacted spoke to [Hospice RN] on call and requested for RN to come back and reassess resident, [Hospice RN] said he will send a nurse. Signed by LVN V. [DATE] 7:42 PM: Writer called resident [Family Member] to update her, said she 5mins aware [sic]. write heard door alarm going off upon arriving noted [Family Member] pulled and held the door until the door opened. [Family Member] called writer to the room and stated what happened to [Resident #2's] right side of head you better call your administrator here or someone this is abuse and neglect because i'm on the phone with the corps [sic] and channel 5 will be here and state will be here too Administrator and DON made aware. Noted redness to resident right side of head, skin assessment performed and no other skin issues noted. Morphine and Xanax administered per [Family Member] request. Police arrived and took statement from writer, hospice contacted again for comfort kit to be delivered spoke to [Hospice nurse] again, said they don't use comfort kit anymore but the nurse is on the way and will place order for atropine [used to decrease mouth secretions and congestion] and other meds needed. Resident made comfortable in bed. [Hospice nurse] here. Administrator and DON arrived. Signed by LVN V. [DATE] 10:18 PM: 9:55 pm Administrator called wanting to talk to residents [Family Member]. Notified the [Family Member] that Admin would like to talk to her on the phone, she said NO I want her to come in the building message relayed to the Administrator. Signed by LVN O. [DATE] 11:00 PM: Skin Only Evaluation: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Skin: Skin warm & dry, skin color WNL and turgor is normal. Resident does not have an external device. Skin note: the skin is intact, small discoloration to the right side scalp noted Signed by RN B. [DATE] 11:19 PM: This resident [Family Member] called at 1515 [3:15 PM] stated Hospice called me .no one called me writer made [Family Member] aware that the change in condition was noted today and previous shift nurse notified hospice. [DATE] 11:45 PM: Resident's [Family Member] called the nurse requesting more pain medication that [Resident #2] seemed to be in much pain and anxiety. 0.25 ml of morphine [pain medication] and XANAX [anxiety medication] 2mg 1 tab administered sublingual and effective. Signed by RN B. [DATE] 2:00 AM: . complete skin assessment done, no skin issues noted except small discoloration on right side of scalp. resident repositioned every 2 hrs and incontinent care provided. Signed by RN B. [DATE] 10:12 AM: [hospice nurse] arrived and pronounced resident at 0916 [9:16 AM]. [funeral home] picked up resident remains at 1012am. Record review of Resident #2's hospice Visit Description Log revealed the following visits made by hospice staff to Resident #2 in [DATE]: [DATE]-Hospice Aide CC [DATE]-Hospice Aide CC [DATE]-Hospice Nurse DD [DATE]-Hospice Aide CC [DATE]-Hospice Aide CC Record review of Resident #2's hospice Physician Order documents revealed medication changes were made for pain control on [DATE] by Hospice Nurse EE, and [DATE] by Hospice Nurse DD and Hospice Nurse FF. No hospice nursing assessments or other visit information were located within Resident #2's electronic medical record. Review of the facility's Provider Investigation Report dated [DATE] reflected Resident #2's Family Member had made an allegation of abuse stating Resident #2 had a bruise on his head. The report reflected the following Description of Injury: Upon charge nurse assessment, no bruise or bump noted on his head, Resident was in the active dying phase. The report reflected the following Provider Response: Charge nurse completed skin assessment and pain assessment. No noted bruising or pain noted. [Resident #2] was currently in the active dying phase and staff were making him comfortable. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Investigation Summary reflected: Based on the investigation; including staff interviews and resident safe surveys, no evidence of abuse can be founded . [Family Member] arrived at the facility after being notified of his decline .charge nurse reported the [Family Member] wanted to visit with the administrator about her concerns . nurse came back and stated the [Family Member] told her, No I won't talk to her on the phone. I expect her to show up at the facility to visit. Administrator and Director of Nursing went to facility She looked at me still yelling, look at these bruises! .I could see the director of nursing go up and look at what she was saying was a bruise. My director of nursing told her he did not see any bruising . Skin assessment and pain assessment completed. No signs of bruising noted . Skin assessments showed no bruising noted on his head An attached Skin Only Evaluation dated [DATE] at 11:00 PM reflected Resident #2's skin was warm and dry, skin color was within normal limits, and turgor (elasticity) was normal. Skin note reflected, the skin is intact, small discoloration to the right-side scalp noted. An attached SBAR Communication Form and Progress Note (used to document a change in condition) dated [DATE] reflected Resident #2's change in condition started on [DATE] and they were unable to determine whether it had gotten worse, better, or stayed the same. -The condition, symptom, or sign had not occurred before. -The resident evaluation reflected boxes checked for altered level of consciousness and needs more assistance with ADLs. -The Pain Evaluation section indicated he had worsening of chronic pain with an intensity of 7 [out of a , d+[DATE] scale, 10 being the worst]. -Code status was DNR. -Appearance was described as Generalized weakness, gasping for air, refused to eat or drink. The Form reflected: Primary Care Clinician Notified: Yes. Date: [DATE] Time: 10:00 AM. Recommendations of Primary Clinicians (if any): [Hospice company name]. No nurses notes were included for additional information. Name of Family/Healthcare Agent Notified: [Family Member] Date: [DATE] Time: 1:00 PM The document was signed by the DON. Record review of photographs obtained from an outside source and identified as those taken of Resident #2 on [DATE] revealed there were two dark pink/purple round bruises approximately 1 cm in diameter on the top right side of his forehead close to his hairline. There was another bruise which was blue and pink and appeared to be raised situated between the two darker pink/purple areas. Another pink area with a scab was observed just inside his hairline on the top right side of his head. (continued on next page)

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F 0580

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Record review of a Police Report, dated [DATE] and provided by the facility, revealed police were dispatched to the nursing facility on [DATE] at 9:04 PM. The report reflected the Police Officer had spoken with resident #2's Family Member who reported being upset that Resident #2 had two contusions and a laceration on his head that could not be explained by facility staff. The Police Officer made contact with LVN V who was unable to locate any documentation of the injuries. The report reflected, I took photographs of [Resident #2's] injuries that were uploaded through [NAME] Capture [police software]. There were no photographs included with the report.

During an interview with Resident #2's Family Member on [DATE] at 10:41 AM, she stated she received a call from the hospice Social Worker at around 5:00 PM on [DATE] stating a hospice had been to visit Resident #2 and his death was imminent. She stated she called his hospice nurse who told her he had not been eating or drinking for three days and the nurse seemed surprised by the information. The Family Member stated the facility should have called the hospice nurse and should have called her as well because she was listed as his emergency contact. The Family Member stated she called the facility right afterward and the nurse told her she was just PRN, had not worked with him for a few days, and was not certain. The Family Member stated she told the nurse she wanted to speak with the ADON or DON and requested a call back. She stated she received a call back from the nurse who told her they did not need to call her because Resident #2 was his own Responsible Party. She stated the nurse confirmed her name and number were listed as his emergency contact. Family Member stated she began stroking Resident #2's head, felt some knots and noticed some bruises that appeared to be in different stages of healing and a hematoma that had a cut in it. She stated she was a nurse herself and was concerned he had been abused. She stated she asked the nurse about it who stated she was unaware, checked and could not find any documentation about it. She stated she again asked to speak with someone in administration. She stated she received no calls from any administrative staff and finally called 911 at around 9:00 PM. She stated the police arrived at about 9:22 PM, spoke with her and took pictures of Resident #2's injuries. Family Member stated, at around 9:46 PM, she stepped out of the room to make a phone call and notices two people in the hallway, a man had his arms crossed and was staring at her. She stated she did not notice and name badges on them and assumed they were there visiting someone else and went on with her call. She stated she returned and the two people entered Resident #2's room and stared at her. She asked them who they were, and they identified themselves as the Administrator and the DON. She stated when she asked them about the injuries on Resident #2's head, the man began aggressively poking on him, so she told him to stop and leave. She stated when she asked them if they were going to call and report the matter, the man laughed, shook his head and guided the Administrator away from the room. The Family Member cried and stated, had she known sooner that Resident #2 was nearing the end, she could have called other family to be there with them, but they lived several hours away. She stated she sat with him alone the rest of the night until he passed away. Family Member stated she was very upset that no one could account for his injuries, and no one had provided any further information since the incident. The Family Member stated she last saw Resident #2 a couple of weeks earlier, near the end of March and he was alert and doing very well. She stated she had not received any prior calls from the facility and only occasional calls from the hospice company, nothing that would have indicated his deterioration or explain his injuries.

The local police department was called on [DATE] at 11:27 AM and a message was left for the responding officer. A request for police report was submitted.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 2:04 PM, LVN Q stated she had previously received in-service training related to abuse, neglect, and injuries of unknown origin. She stated any concerns or complaints related to abuse or neglect should be reported to the Administrator immediately. LVN Q stated, if bruises or injuries were noted, she would check the notes to see if a previous nurse had documented anything. She stated, if not, she should have assessed the resident, contacted the resident's physician, and noted any new orders, notify the family and notify the Administrator and DON. LVN Q stated the risk of failing of notify the emergency contact was it could upset the family very much if they didn't know, they need to know. She stated the family needed to know even if the resident was their own responsible party. When asked about Resident #2 and the events on [DATE], LVN Q stated that day he started to decline, she had called hospice and they arrived later after her shift. She could not recall who she had spoken with. She stated she did not call his family because there was no emergency contact listed. When shown Resident #2's Admission Record with the Family Member's phone number, she stated she thought hospice was going to call them. She stated, I accept I made mistakes; it was the first time I had anyone decline like that and I should have called [Family Member]. LVN Q stated she had assessed Resident #2 and did not recall any skin issues. She stated administration had called her later that evening and asked whether she had noticed any injuries and she told them no. She stated she never spoke with his family. During a telephone interview on [DATE] at 6:38 PM, the police officer who had responded to the call related to Resident #2, he stated he recalled speaking to Resident #2's Family Member. The police officer stated he recalled seeing a knot and some bruises on Resident #2's head. He stated he spoke with facility staff and he was unable to determine how the injuries were sustained. During an interview with ADON AA on [DATE] at 8:50 AM, she identified herself as the facility's wound treatment nurse and began working in the facility in February 2024. She stated the nursing staff reported any new skin findings to her. She stated her responsibilities included assessing all facility wounds, including bruises and skin tears. She stated, if the wound was new, she requested treatment orders and notified family members. ADON AA stated she had never been notified of any skin conditions for Resident #2 and he had never been on her service. In an interview on [DATE] at 9:04 AM, the DON stated the procedures for a change in condition for residents receiving hospice services were the charge nurse was to call the hospice providers because they handled the orders. He stated the hospice nurses would usually indicate if they were going to contact the resident's family members and, if not, the charge nurse was to contact them. He stated any changes in a resident's condition and calls made related to the residents were documented in the progress notes. In an interview on [DATE] at 10:50 AM, LVN BB stated she had been caring for two hospice residents. She stated any changes in the resident's condition were called to the hospice nurse and the resident's family. She stated it was important to call the family because she could not be certain if the hospice nurse contacted them, and it was important they were notified of any changes. On [DATE] at 12:11 PM, attempts to call Resident #2's hospice company were unsuccessful, and no voice mailbox was available. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:20 PM, CNA U stated she had been working at the facility for two years and had begun working as a Restorative Aide about a month ago. She stated she had cared for Resident #2 during his stay. She stated she had noticed he was declining during the last week he was there. She stated, I'm a reporter, always go to the nurse first, anything I find out of the ordinary or I haven't seen before. When asked about his skin care, CNA U stated the hospice aides typically performed bathing, but the facility aides did everything else. When asked about the week leading up to [DATE], CNA U stated she was pretty sure there was a wound on his head, and she was pretty sure he had hit his head. CNA U stated she had entered his room and found him leaning out of the bed. She stated the upper part of his body was leaning to the side out of the bed, his right hand was on the floor, and his left hand was holding onto his bedside table as if trying to keep himself from falling to the floor. She stated he had a dresser and an oxygen concentrator next to his bed. CNA U stated she asked him what he was trying to do, and he was confused. She stated she assisted him back onto the bed and noticed his head was bleeding. She stated she thought he had hit his head on his oxygen concentrator. She stated she went to get the nurse and was pretty sure it was LVN Q. CNA U was unable to recall on what day the incident occurred but thought it was one or two days before Resident #2 died . She stated the nurse came, checked his vital signs and cleaned his wound. She stated the incident occurred near the end of her shift and she went home. When asked if she had cared for him in the days after the incident, she replied, I might have but I don't remember. She stated she could not recall any other incidents involving Resident #2, but she could tell he was declining before the incident. She stated he had previously been able to tell them what he needed. CNA U stated she had previously had training about abuse and neglect and knew any incidents were to be reported to the Administrator and DON. She stated she did not report that incident because the nurse was caring for him and she assumed the nurse would have reported it. CNA U stated she did recall the DON later asking about Resident #2's skin and stated, I think I told him no though, I think I forgot. During another interview with LVN Q on [DATE] at 12:53 PM, when she was asked again about any skin issues with Resident #2, she replied, I checked, no issues. When asked whether she had received any reports that he had stopped eating, she stated she had only heard about his refusing to eat on [DATE] .I didn't see her [hospice nurse] before I left. LVN Q denied ever being told by CNA U that Resident #2 was found leaning out of bed with his head bleeding. She denied seeing any bruising or cuts on his head. LVN Q was shown the photos of Resident #2 obtained during the investigation. She stated, I did see the cut, I don't recall seeing the bruises. He was not hanging out of the bed, he was more to the side of the bed. We repositioned him. She pointed out the cut and stated, Yes, I saw that one, I cleaned it, it was a small cut. I told the hospice nurse that day, they came, and I reported the cut. She stated she did not report the injury to Resident #2's physician or his family member. She could not recall they day it occurred and stated, I called the hospice nurse and saw them the same day. She stated she thought it may have occurred the same day he had declined on [DATE]. When reminded she had already stated she never saw the hospice nurse on [DATE], she replied, Right. LVN Q stated she did not document the incident or injury anywhere and could not say why she did not. She stated she had only reported it verbally to the hospice nurse. She stated she had received training on abuse and neglect and should have reported the incident and completed an incident report. She stated she did not tell the DON about it when he had contacted her on the evening of [DATE] and asked her specifically about any injuries. She stated she forgot to tell him. LVN Q stated the risk for failing to report incidents and injuries was great injury and harm and apologized for her mistakes. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:16 PM, the DON was asked about the incident related to Resident #2 on [DATE]. He stated Resident #2 had been on hospice. The DON stated, on [DATE], Resident #2's nurse had notified hospice that he needed increased care and was told they would send someone out. He stated they did not arrive until later that evening, and he was not there when they arrived. The DON stated he had only come in later that evening because Resident #2's Family Member had complained of bruises, so he and the Administrator came to the facility. The DON stated he checked Resident #2 and there was nothing there other than typical color changes seen when someone was dying. The DON stated Resident #2's Family Member had not seen Resident #2 in years. He said he knew this because he had not seen her in the facility and their Social Worker had said the same. He stated they had attempted to contact the Family Member when After Resident #2 had returned from his last hospital trip and had elected to go onto hospice services. He stated Resident #2 had identified the Family Member as his emergency contact. He stated the nurses reported they had tried to reach the Family Member when Resident #2 had stopped eating but no one was picking up the phone. He stated he thought it was LVN Q or one of the other nurses who had given him that information. He stated he did not follow up on the calls because the hospice nurse was following up. The DON stated he was told the Family Member was irate, had called the police, and complained Resident #2 had an injury to his head and wanted to know what had happened. He stated the police were gone when he arrived. He stated he and the Administrator spoke with the nurse, went to Resident #2's room to speak with them and the hospice nurse was there. He stated the Family Member stepped out a short time later and he went in to assess Resident #2. The DON stated, I went in and assessed him, didn't see bruises or anything, just skin discoloration. He stated he called and spoke with LVN Q and CNA U to see whether they had seen anything and both [NAME] him no. He stated he spoke LVN V who was caring for him during the 2 PM to 10 PM shift. When asked whether he had seen the police report-the DON stated he had glanced at it. He did not recall seeing any photographs of Resident #2's injuries or the area on the report that indicated photographs were taken. The DON stated the Family Member told him there was something there, I didn't see anything, everyone I talked to said they didn't see anything. When the DON was shown the photos obtained during the investigation, he stated he did see the red spots. He stated he told the night shift nurse to complete a skin assessment. When asked about the blue raised area or the scabbed area, he stated he had not seen them during his assessment. He stated the room was dim and he did not look in the resident's hair. When asked why he did not document the red spots he had observed, the DON stated they had a nurse on the floor to do that. The facility's Provider Investigation Report was reviewed with the DON, and he was asked about the fact that he was identified as stating there were no signs of bruising noted. The DON stated he had attributed the areas he saw as skin changes due to the dying process and he did not believe they were bruises. The DON was informed of the information received during interviews with CNA U and LVN Q including their admission of noting Resident #2 had sustained an injury to his head and their failure to report the information. The DON stated he was previously unaware of the situation and repeated he had reached out to both of them to ask if they knew anything and was told no. The DON stated failure to report incidents and injuries placed the residents at risk of missed injuries and delayed treatment. He stated he expected his staff to follow their incident reporting protocol and report any incidents or injuries to himself and the Administrator. He was asked again to assist with locating the resident's hospice documentation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arden Place of Richland Hills	7146 Baker Blvd Richland Hills, TX 76118

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Administrator A on [DATE] at 4:20 PM revealed the DON had spoken with her regarding the interview related to Resident #2. She stated she felt confident the staff interviews had been conducted during the investigation and staff surveys were conducted with other staff as well. She stated, on [DATE], she had received a call from the facility stating Resident #2's Family Member was upset. She stated she did not attempt to reach the Family Member on their phone because she did not have the number and had been told they wanted her to come to the facility. Administrator A stated she arrived at the facility and she stood near the doorway while the DON was speaking with the Family Member and she heard her say something about a gash and a bruise. Administrator A stated the Family Member was pointing toward Resident #2's head but she was unable to see anything from where she was standing. Administrator stated she asked the Family Member if they could tell her what was wrong, and she was told he had a bruise and a gash on his head. She stated she was unable to see it from where she was standing. Administrator A stated when she arrived the next morning, Resident #2 had died . She stated she looked at Resident #2 and did not see anything on the front of his forehead. She stated she was not a nurse, so she did not touch the resident. She stated she asked the DON, and he told her he had not seen anything. Administrator A was shown the photographs obtained during the investigation and she stated she did not see the injuries shown in the photographs when she observed Resident #2. She stated they could have been covered by his hair and she did not touch him. The DON joined the interview with Administrator A. The DON stated he spoke with LVN Q who insisted the injury to Resident #2's head occurred on [DATE] and that she had called the hospice company but had failed to document it and the hospice nurse arrived after she had gone home that day Administrator A stated the DON had shared with her already that the information they had received during their initial investigation was not what was learned this day. Administrator A stated if a resident was found with a head injury or any new injury, the nurse should notify the physician and family. She stated the nurse should then immediately notify herself and the DON so they could properly follow-up and investigate. Administrator A stated she expected the nurses to document and at least have a note documenting the assessment, the vital signs, a note detailing what happened. She stated notification of the physician and family should be noted as well and an incident report initiated. She stated she expected the nurse to treat any wounds and do whatever the situation entailed. She stated it could be many different scenarios. Administrator A stated there was always a risk of negative outcomes for residents sustaining injuries that were not reported. During an interview on [DATE] at 4:55 PM, Administrator A stated LVN Q had been suspended pending investigation. During an interview with the DON on [DATE] at 7:45 AM, he stated he was still unable to locate any additional hospice documentation for Resident #2. He stated he had been unable to reach anyone at the hospice company when he attempted on [DATE]. A copy of the hospice contact information was provided. In an interview on [DATE] at 8:42 AM, the DON was provided with the Hospice Representative's name and email address. He was asked to send an email request for all of Resident #2's hospice documentation, call logs and list of contact numbers for Resident #2's nurses and CNAs. The DON began drafting the email request as we spoke. He stated he would r [TRUNCATED]

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observation, interview, and record review the facility failed to ensure residents in the facility were free from neglect for 1 (Resident #2) of 5 residents reviewed for neglect. LVN Q failed to document the assessment and treatment she performed on Resident #2. LVN Q failed to perform any additional assessments of the resident's injury and notify any other staff of the injury. These failures placed residents at risk of pain, diminished quality of life, delayed diagnosis, treatment, and serious physical harm. Findings included: Record review of Resident #2's Admission Record dated [DATE] revealed he was a [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE]. Under Contacts, Resident #2 was listed as being his own responsible party and the name and phone number Resident #2's Family Member was included. Record review of Resident #2's Significant Change MDS assessment dated [DATE] revealed he had diagnoses including anemia (lack of enough red blood cells needed to carry oxygen throughout the body), orthostatic hypotension (low blood pressure that happens when sitting or lying down that can cause dizziness), cirrhosis (liver damage), anxiety, depression, and chronic obstructive pulmonary disease (lung disease that can make breathing difficult). He had clear speech, he was usually understood and could usually understand others. He had a BIMS score of 11 indicating he had moderately impaired cognition. The MDS reflected it was very important for him to have his family or close friend involved in discussions about his care and he required substantial/maximum assistance to transfer from his bed to a chair. The MDS reflected he was almost constantly in pain that frequently made it hard to sleep and he had sustained one fall since readmission with no injury. He was receiving hospice care while a resident. Record review of Resident #2's Care Plans revealed an entry dated initiated [DATE] that reflected, [Resident #2] has had an actual fall r/t Unsteady gait [DATE]. Interventions/Tasks included checking range of motion and providing activities that promote exercise and strength building where possible. There were no facility care plans related to his hospice care. Record review of Resident #2's Physician's orders revealed an entry dated [DATE] which reflected, admitted to [hospice company name] Hospice diagnosis of [COPD] . Record review of Resident #2's Progress Notes reflected the following nursing entries for [DATE]: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 6:29 AM: Resident continued to call [Hospice company] complaining that he is in pain and needs Morphine. The Hospice nurse come to the facility, one time order for Morphine sulfate 30 mg tab was administered and effective. also new orders give: to D/C Morphine Sulfate30 mg ab po qhs, continue Morphine Sulfate 60 mg tab BID, Hydromorphone 2 mg 1 tab every 6 hrs prn for mild and moderate pain and dyspnea and 2 tabs every 6 hrs prn for severe pain and dyspnea. the new orders were immediately sent to pharmacy electronically by [Hospice company] Nurse. Signed by RN B. [DATE] 11:57 AM: Skin Only Evaluation. Skin: Skin warm & dry, skin color WNL and turgor is normal. Resident does not have an external device. Signed by the DON. [DATE] 10:21 PM: Resident refused medications this shift. Signed by LVN V. [DATE] 7:51 AM LATE ENTRY Situation: The Change In Condition/s reported on this CIC Evaluation are/were: Abnormal vital signs (low/high BP, heart rate, respiratory rate, weight change) Seems different than usual At the time of evaluation resident/patient vital signs, weight and blood sugar were: - Blood Pressure: BP ,d+[DATE] - [DATE] 07:53 Position: Lying r/arm - Pulse: P 68 - [DATE] 07:54 Pulse Type: Irregular - new onset - RR: R 26 - [DATE] 07:54 - Temp: T 97.1 - [DATE] 07:55 Route: Tympanic - Weight: W 130.0 lb -[DATE] 09:36 Scale: Wheelchair - Pulse Oximetry: O2 81 % - [DATE] 07:55 Method: Oxygen via Nasal Cannula - Blood Glucose: Resident/Patient is in the facility for: Long Term Care Primary Diagnosis is: K74.60 UNSPECIFIED CIRRHOSIS OF LIVER . R53.1 WEAKNESS R29.6 REPEATED FALLS J44.9 CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED I95.89 OTHER HYPOTENSION Relevant medical history is: COPD Code Status: DNR (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Advance directives are: Resident/Patient had the following medications changes in the past week: Resident/Patient is on Coumadin/warfarin [blood thinners]: No The result of last INR: Date: Resident/Patient is on anticoagulant [blood thinner] other than warfarin: No Resident/Patient is on: Outcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were: - Mental Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) - Functional Status Evaluation: Needs more assistance with ADLs - Behavioral Status Evaluation: - Respiratory Status Evaluation: - Cardiovascular Status Evaluation: - Abdominal/GI Status Evaluation: No changes observed - GU/Urine Status Evaluation: No changes observed - Skin Status Evaluation: No changes observed - Pain Status Evaluation: Does the resident/patient have pain? Yes - Neurological Status Evaluation: No changes observed Nursing observations, evaluation, and recommendations are: Generalized weakness, gasping for air, refused to eat or drink. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: [name of hospice] HOSPICE B. New Testing Orders: [blank] C. New Intervention Orders: [blank]-- Comments: [blank] (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Signed by LVN Q and the DON.

[DATE] 3:03 PM: Hospice nurse here at beginning n/o rec'd to crush meds mix with applesauce put under the in the check or under the tongue. Ativan Qhrs as needed DX anxiety. Signed by LVN V.

[DATE] 4:27 PM: V/S assessed ,d+[DATE],68,16,97.8, 96% O2 @ 2 via n/c, resident not responding when called by his name, and unable to eat or drink. [name of hospice] hospice contacted spoke to [Hospice RN] on call and requested for RN to come back and reassess resident, [Hospice RN] said he will send a nurse. Signed by LVN V.

[DATE] 7:42 PM: Writer called resident [Family Member] to update her, said she 5mins aware [sic]. write heard door alarm going off upon arriving noted [Family Member] pulled and held the door until the door opened. [Family Member] called writer to the room and stated what happened to [Resident #2's] right side of head you better call your administrator here or someone this is abuse and neglect because I'm on the phone with the corps [sic] and channel 5 will be here and state will be here too Administrator and DON made aware. Noted redness to resident right side of head, skin assessment performed and no other skin issues noted. Morphine and Xanax administered per [Family Member] request. Police arrived and took statement from writer, hospice contacted again for comfort kit to be delivered spoke to [Hospice nurse] again, said they don't use comfort kit anymore but the nurse is on the way and will place order for atropine [used to decrease mouth secretions and congestion] and other meds needed. Resident made comfortable in bed. [Hospice nurse] here. Administrator and DON arrived. Signed by LVN V.

[DATE] 10:18 PM: 9:55 pm Administrator called wanting to talk to residents [Family Member]. Notified the [Family Member] that Admin would like to talk to her on the phone, she said 'NO I want her to come in the building' message relayed to the Administrator. Signed by LVN O.

[DATE] 11:00 PM: Skin Only Evaluation:

Skin: Skin warm & dry, skin color WNL and turgor is normal.

Resident does not have an external device.

Skin note: the skin is intact, small discoloration to the right side scalp noted Signed by RN B.

[DATE] 11:19 PM: This resident [Family Member] called at 1515 [3:15 PM] stated Hospice called me and told me [Resident #2] has not eaten for the past three days and no one called me writer made [Family Member] aware that the change in condition was noted today and previous shift nurse notified hospice.

[DATE] 11:20 PM: Hospice nurse was in resident's room with resident's [Family Member] the time this nurse arrived and doing her round. new orders are given from Hospice nurse to give Dilaudid [pain medication] 2mg tab ,d+[DATE] tabs every 2 hours as needed for pain or SOB. Hyoscyamine 0.125 mg 1 tab sublingually every 4 hours as needed for excess secretions. TO hold scheduled meds and food, drink due to inability to swallow. PRN meds can be crushed, mixed with water with 0.25 ml of water and give sublingually [under the tongue]. Signed by RN B.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 11:30 PM: this nurse noticed resident's room call light on, arrived there, the hospice nurse said that the resident needs pain med. Dilaudid 2mg 1 tab administered sublingually. resident's [Family Member] on side of bed. Signed by RN B. [DATE] 11:45 PM: Resident's [Family Member] called the nurse requesting more pain medication that [Resident #2] seemed to be in much pain and anxiety. 0.25 ml of morphine [pain medication] and XANAX [anxiety medication] 2mg 1 tab administered sublingual and effective. Signed by RN B. [DATE] 2:00 AM: Resident is declining, vital signs BP ,d+[DATE], P 108, R 14, 02SAT 79 on oxygen. resident's body is sweating but temperature reads low. hospice nurse is aware of changes of condition. after giving new orders, hospice nurse left saying that he will come back later in day. complete skin assessment done, no skin issues noted except small discoloration on right side of scalp. resident repositioned every 2 hrs and incontinent care provided. Signed by RN B. [DATE] 2:35 AM: Hydromorphone 2mg 2 tablets administered for pain. resident remains on comfort care. Signed by RN B. [DATE] 7:07 AM: V/S assessed at 0707 unpon [sic] arrival to the facility ,d+[DATE],107,12,97.1 sat 72%-75% on 02. [Family Member] at bedside. Signed by LVN V. [DATE] 7:54 AM: Approx 0722 went to administer pain meds, no rise and fall of chest noted, [Family Member] stated 'i think he's gone and writer unable to obtain any V/S. Vitas hospice contacted spoke [Hospice nurse] on call, said she will send a nurse out, [Family Member] made aware. DON and [doctor] notified. Resident cleaned at this time by writer, call light within reach. Signed by LVN V. [DATE] 10:12 AM: [hospice nurse] arrived and pronounced resident at 0916 [9:16 AM]. [funeral home] picked up resident remains at 1012am. Record review of Resident #2's hospice Visit Description Log revealed the following visits made by hospice staff to Resident #2 in [DATE]: [DATE]-Hospice Aide CC [DATE]-Hospice Aide CC [DATE]-Hospice Nurse DD [DATE]-Hospice Aide CC [DATE]-Hospice Aide CC Record review of Resident #2's hospice Physician Order documents revealed medication changes were made for pain control on [DATE] by Hospice Nurse EE, and [DATE] by Hospice Nurse DD and Hospice Nurse FF. No hospice nursing assessments or other visit information were located within Resident #2's electronic medical record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Provider Investigation Report dated [DATE] reflected Resident #2's Family Member had made an allegation of abuse stating Resident #2 had a bruise on his head. The report reflected the following Description of Injury: Upon charge nurse assessment, no bruise or bump noted on his head, Resident was in the active dying phase. The report reflected the following Provider Response: Charge nurse completed skin assessment and pain assessment. No noted bruising or pain noted. [Resident #2] was currently in the active dying phase and staff were making him comfortable. The Investigation Summary reflected: Based on the investigation; including staff interviews and resident safe surveys, no evidence of abuse can be founded. [Resident #2] was alert and oriented and able to make all needs known prior to his medical decline. [Family Member] arrived at the facility after being notified of his decline. It was at this time once she arrived, according to staff that she started yelling at staff; unplugged the call light, called police department and threatened to call the news station. Charge nurse called the administrator and reported [Family Member] was exhibiting some unruly and inappropriate behavior, yelling at the staff, calling the police (police showed up) and charge nurse reported the [Family Member] wanted to visit with the administrator about her concerns. Administrator attempted multiple times to visit with [Family Member], via phone unsuccessful. At approximately 10:00 pm, administrator attempted to visit with the [Family Member] via phone again, nurse came back and stated the [Family Member] told her, No I won't talk to her on the phone. I expect her to show up at the facility to visit. Administrator and Director of Nursing went to facility. Both admin and the director of nursing arrived a little after 10:30 pm and I attempted to introduce myself to the [Family Member]. She said, Who are you? I explained who I was, and she started yelling at me stating you need to get out of here. I explained to her that she asked me to come. I came and wanted to hear her concerns. She looked at me still yelling, look at these bruises! I attempted to look, but she said, you are not welcome in here. You need to leave. I did step out of the room, but I stayed at the doorway, and I could see the director of nursing go up and look at what she was saying was a bruise. My director of nursing told her he did not see any bruising. Then she kicked the director of nursing out too. At that time, the Director of Nursing and administrator started investigation. Skin assessment and pain assessment completed. No signs of bruising noted. [Resident #2] was nonresponsive as he was actively dying. No signs or symptoms of distress noted. Charge nurse continued to provide palliative and comfort care through the night. Skin assessments showed no bruising noted on his head. [Resident #2] passed early the next day; [Family Member] stayed the night and left in the morning once he passed. Charge nurse stated [Family Member] was calm all night long and did not continue yelling behavior. [Resident #2] was on hospice for end stage disease. Resident safe surveys completed. No concerns noted. Staff safe surveys completed. No concerns noted. An attached Skin Only Evaluation dated [DATE] at 11:00 PM reflected Resident #2's skin was warm and dry, skin color was within normal limits, and turgor (elasticity) was normal. Skin note reflected, the skin is intact, small discoloration to the right-side scalp noted. An attached SBAR Communication Form and Progress Note (used to document a change in condition) dated [DATE] reflected Resident #2's change in condition started on [DATE] and they were unable to determine whether it had gotten worse, better, or stayed the same. -The condition, symptom, or sign had not occurred before. -The resident evaluation reflected boxes checked for altered level of consciousness and needs more assistance with ADLs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Pain Evaluation section indicated he had worsening of chronic pain with an intensity of 7 [out of a , d+[DATE] scale, 10 being the worst]. -Code status was DNR. -Appearance was described as Generalized weakness, gasping for air, refused to eat or drink. The Form reflected: Primary Care Clinician Notified: Yes. Date: [DATE] Time: 10:00 AM. Recommendations of Primary Clinicians (if any): [Hospice company name]. No nurses notes were included for additional information. Name of Family/Healthcare Agent Notified: [Family Member] Date: [DATE] Time: 1:00 PM The document was signed by the DON. Record review of photographs obtained from a confidential person, identified as those taken of Resident #2 on [DATE] revealed there were two dark pink/purple round bruises approximately 1 cm in diameter on the top right side of his forehead close to his hairline. There was another bruise which was blue and pink and appeared to be raised situated between the two darker pink/purple areas. Another pink area with a scab was observed just inside his hairline on the top right side of his head. Record review of a Police Report, dated [DATE] and provided by the facility, revealed police were dispatched to the nursing facility on [DATE] at 9:04 PM. The report reflected the Police Officer had spoken with resident #2's Family Member who reported being upset that Resident #2 had two contusions and a laceration on his head that could not be explained by facility staff. The Police Officer made contact with LVN V who was unable to locate any documentation of the injuries. The report reflected, I took photographs of [Resident #2's] injuries that were uploaded through [NAME] Capture [police software]. There were no photographs included with the report. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #2's Family Member on [DATE] at 10:41 AM, she stated she received a call from the hospice Social Worker at around 5:00 PM on [DATE] stating a hospice had been to visit Resident #2 and his death was imminent. She stated she called his hospice nurse who told her he had not been eating or drinking for three days and the nurse seemed surprised by the information. The Family Member stated the facility should have called the hospice nurse and should have called her as well because she was listed as his emergency contact. The Family Member stated she called the facility right afterward and the nurse told her she was just PRN, had not worked with him for a few days, and was not certain. The nurse told her his tray had just been delivered and she would check on him. The Family Member stated she told the nurse she wanted to speak with the ADON or DON and requested a call back. She stated she received a call back from the nurse who told her they did not need to call her because Resident #2 was his own Responsible Party. She stated she became angry and demanded a call back from someone in charge. She stated the nurse confirmed her name and number were listed as his emergency contact. The Family Member stated when she arrived to Resident #2's room, a hospice chaplain was present with Resident #2 he stated she began stroking Resident #2's head, felt some knots and noticed some bruises that appeared to be in different stages of healing and a hematoma that had a cut in it. She stated she was a nurse herself and was concerned he had been abused. She stated she asked the nurse about it who stated she was unaware, checked and could not find any documentation about it. She stated she became infuriated and again asked to speak with someone in administration. She stated she received no calls and finally called 911 at around 9:00 PM. She stated the police arrived at about 9:22 PM, spoke with her and took pictures of Resident #2's injuries. The Family Member stated she missed a call from the ADON while the police were there and did not bother to call them back. She stated, at around 9:46 PM, she stepped out of the room to make a phone call and notices two people in the hallway, a man had his arms crossed and was staring at her. She stated she did not notice and name badges on them and assumed they were there visiting someone else and went on with her call. She stated she returned and the two people entered Resident #2's room and stared at her. She asked them who they were, and they identified themselves as the Administrator and the DON. She stated when she asked them about the injuries on Resident #2's head, the man began aggressively poking on him, so she told him to stop and leave. She stated when she asked them if they were going to call and report the matter, the man laughed, shook his head and guided the Administrator away from the room. The Family Member cried and stated, had she known sooner that Resident #2 was nearing the end, she could have called other family to be there with them, but they lived several hours away. She stated she sat with him alone the rest of the night until he passed away. The Family Member stated the nurses who cared for him that night were very kind and compassionate. She stated she was very upset that no one could account for his injuries, and no one had provided any further information since the incident. The Family Member stated she last saw Resident #2 a couple of weeks earlier, near the end of March and he was alert and doing very well. She stated she brought him his favorite snacks and he was happy watching his favorite western movies. She stated she had not received any prior calls from the facility and only occasional calls from the hospice company, nothing that would have indicated his deterioration or explain his injuries. The local police department was called on [DATE] at 11:27 AM and a message was left for the responding officer. A request for police report was submitted. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arden Place of Richland Hills	7146 Baker Blvd Richland Hills, TX 76118

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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 - Few	In an interview on [DATE] at 2:04 PM, LVN Q stated she had previously received in-service training related to abuse, neglect, and injuries of unknown origin. She stated any concerns or complaints related to abuse or neglect should be reported to the Administrator immediately. LVN Q stated, if bruises or injuries were noted, she would check the notes to see if a previous nurse had documented anything. She stated, if not, she should have assessed the resident, contacted the resident's physician, and noted any new orders, notify the family and notify the Administrator and DON. LVN Q stated the risk of failing of notify the emergency contact was it could upset the family very much if they didn't know, they need to know. She stated the family needed to know even if the resident was their own responsible party. When asked about Resident #2 and the events on [DATE], LVN Q stated that day he started to decline, she had called hospice and they arrived later after her shift. She could not recall who she had spoken with. She stated she did not call his family because there was no emergency contact listed. When shown Resident #2's Admission Record with the Family Member's phone number, she stated she thought hospice was going to call them. She stated, I accept I made mistakes; it was the first time I had anyone decline like that and I should have called [Family Member]. LVN Q stated Resident #2 had stopped eating and was only taking sips of water. She stated she cared for him the day before and he was fine. LVN Q stated she had assessed Resident #2 on [DATE] and did not recall any skin issues . She stated administration had called her later that evening and asked whether she had noticed any injuries and she told them no. She stated she never spoke with his family. During a telephone interview on [DATE] at 6:38 PM, the police officer who had responded to the call related to Resident #2, he stated he recalled speaking to Resident #2's Family Member. The police officer stated he recalled seeing a knot and some bruises on Resident #2's head. He stated he spoke with facility staff and he was unable to determine how the injuries were sustained. During an interview with ADON AA on [DATE] at 8:50 AM, she identified herself as the facility's wound treatment nurse and began working in the facility in February 2024. She stated the nursing staff reported any new skin findings to her. She stated her responsibilities included assessing all facility wounds, including bruises and skin tears. She stated, if the wound was new, she requested treatment orders and notified family members. ADON AA stated she had never been notified of any skin conditions for Resident #2 and he had never been on her service. In an interview on [DATE] at 9:04 AM, the DON stated the procedures for a change in condition for residents receiving hospice services were the charge nurse was to call the hospice providers because they handled the orders. He stated the hospice nurses would usually indicate if they were going to contact the resident's family members and, if not, the charge nurse was to contact them. He stated any changes in a resident's condition and calls made related to the residents were documented in the progress notes. The DON stated the hospice providers left binders at the nurses' stations with the residents' hospice documentation. The DON was asked to provide all hospice documentation related to Resident #2. In an interview on [DATE] at 10:50 AM, LVN BB stated she had been caring for two hospice residents. She stated the hospice companies kept binders at the nurses' stations that contained the resident's hospice documents. She stated any changes in the resident's condition were called to the hospice nurse and the resident's family. She stated it was important to call the family because she could not be certain if the hospice nurse contacted them, and it was important they were notified of any changes. She stated she had not cared for Resident #2 during his stay there. A contact number for the hospice company used by Resident #2 was provided by LVN BB as it was the same utilized by her residents. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:11 PM, attempts to call Resident #2's hospice company were unsuccessful, and no voice mailbox was available. During an interview on [DATE] at 12:20 PM, CNA U stated she had been working at the facility for two years and had begun working as a Restorative Aide about a month ago. She stated she had cared for Resident #2 during his stay. She stated she had noticed he was declining during the last week he was there. She stated, [Resident #2] used to feed himself, then I had to feed him, then he wouldn't take anything. He wouldn't open his mouth for food and would sleep more. She stated anything she found like that, she would report to the nurse. She stated she knew she had reported it to LVN Q and she would attempt to feed him. She stated the thought she recalled reporting it to LVN W as well. She stated, I'm a reporter, always go to the nurse first, anything I find out of the ordinary or I haven't seen before. She stated she documented the resident's meal intakes in the computer software. When asked about his skin care, CNA U stated the hospice aides typically performed bathing, but the facility aides did everything else. When asked about the week leading up to [DATE], CNA U stated she was pretty sure there was a wound on his head, and she was pretty sure he had hit his head. CNA U stated she had entered his room and found him leaning out of the bed. She stated the upper part of his body was leaning to the side out of the bed, his right hand was on the floor, and his left hand was holding onto his bedside table as if trying to keep himself from falling to the floor. She stated he had a dresser and an oxygen concentrator next to his bed. CNA U stated she asked him what he was trying to do, and he was confused. She stated she assisted him back onto the bed and noticed his head was bleeding. She stated she thought he had hit his head on his oxygen concentrator. She stated she went to get the nurse and was pretty sure it was LVN Q. CNA U was unable to recall on what day the incident occurred but thought it was one or two days before Resident #2 died . She stated the nurse came, checked his vital signs and cleaned his wound but did not state how or what items she used to cleanse Resident #2's wound. She stated the incident occurred near the end of her shift and she went home. When asked if she had cared for him in the days after the incident, she replied, I might have but I don't remember. She stated she could not recall any other incidents involving Resident #2, but she could tell he was declining before the incident. She stated he had previously been able to tell them what he needed. CNA U stated she had previously had training about abuse and neglect and knew any incidents were to be reported to the Administrator and DON. She stated she did not report that incident because the nurse was caring for him and she assumed the nurse would have reported it. CNA U stated she did recall the DON later asking about Resident #2's skin and stated, I think I told him no though, I think I forgot. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During another interview with LVN Q on [DATE] at 12:53 PM, when she was asked again about any skin issues with Resident #2, she replied, I checked, no issues. When asked whether she had received any reports that he had stopped eating, she stated she had only heard about his refusing to eat on [DATE] and stated, that's why I called the hospice nurse, they said they would tell his nurse to come. I didn't see her before I left. LVN Q denied ever being told by CNA U that Resident #2 was found leaning out of bed with his head bleeding. She denied seeing any bruising or cuts on his head. LVN Q was shown the photos of Resident #2 obtained during the investigation. She stated, I did see the cut, I don't recall seeing the bruises. He was not hanging out of the bed, he was more to the side of the bed. We repositioned him. She pointed out the cut and stated, Yes, I saw that one, I cleaned it, it was a small cut. I told the hospice nurse that day, they came, and I reported the cut. She stated she did not report the injury to Resident #2's physician or his family member. She could not recall they day it occurred and stated, I called the hospice nurse and saw them the same day. She stated she thought it may have occurred the same day he had declined on [DATE]. When reminded she had already stated she never saw the hospice nurse on [DATE], she replied, Right. LVN Q stated she did not document the incident or injury anywhere and could not say why she did not. She stated she had only reported it verbally to the hospice nurse. She stated she had received training on abuse and neglect and should have reported the incident and completed an incident report. She stated she did not tell the DON about it when he had contacted her on the evening of [DATE] and asked her specifically about any injuries. She stated she forgot to tell him. LVN Q stated the risk for failing to report incidents and injuries was great injury and harm and apologized for her mistakes. During an interview on [DATE] at 1:16 PM, the DON was asked about the incident related to Resident #2 on [DATE]. He stated Resident #2 had been on hospice and had been in decline for 2 to 3 days before then, staying in bed and not eating. He stated he knew that because he would pass through and saw the nurses' notes. He stated he was unsure whether his meal percentages had been documented in the computer system. The DON stated, on [DATE], Resident #2's nurse had notified hospice that he needed increased care and was told they would send someone out. He stated they did not arrive until later that evening, and he was not there when they arrived. The DON stated he had only come in later that evening because Resident #2's Family Member had complained of bruises, so he and the Administrator came to the facility. The DON stated he checked Resident #2 and there was nothing there other than typical color changes seen when someone was dying. The DON stated Resident #2's Family Member had not seen Resident #2 in years. He said he knew this because he had not seen her in the facility and their Social Worker had said the same. He stated they had attempted to contact the Family Member when After Resident #2 had returned from his last hospital trip and had elected to go onto hospice services. He stated, at that time, the Family Member had instructed them to allow Resident #2 to make that decision. He stated Resident #2 had identified the Family Member as his emergency contact. He stated the nurses reported they had tried to reach the Family Member when Resident #2 had stopped eating but no one was picking up the phone. He stated he thought it was LVN Q or one of the other nurses who had given him that information. He stated he did not follow up on the calls because the hospice nurse was following up. The DON stated he was told the Family Member was irate, had called the police, and complained Resident #2 had an injury to his head and wanted to know what had happened. He stated the police were gone when he arrived. He stated he and the Administrator spoke with the nurse, went to Resident #2's room to speak with them and the hospice nurse was there. He stated the Family Member [TRUNCATED]

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

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 35747

Based on observations, interviews, and record reviews, the facility failed to ensure residents received adequate supervision and assistive devices to prevent accidents for one of seven residents (Resident #1) reviewed for supervision.

The facility failed to ensure Resident #1 was adequately supervised in order to prevent her from eloping from the facility. Resident #1 first eloped from the facility on 12/19/23. As a result of the elopement, she was placed on the secured unit at the facility. However, the facility continued to fail to provide adequate supervision and Resident #1 eloped from the facility for the second time on 05/04/24.

An Immediate Jeopardy (IJ) was identified on 07/24/24 at 4:19PM. The IJ template was provided to the facility on [DATE] at 4:45PM and signed by Administrator A. While the IJ was removed on 07/26/24 the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of isolated due to the facility still monitoring the effectiveness of their Plan of Removal.

This failure placed residents at risk for not being adequately supervised and the potential for serious injury and/or death.

Findings included:

Review of Resident #1's Face Sheet, dated 07/24/24, reflected she was a [AGE] year-old female who most recently admitted to the facility on [DATE].

Review of Resident #1's MDS Assessment, dated 06/07/24, reflected she was identified as having severe cognitive impairment. Resident #1 had diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and depression (a mental disorder that can affect how someone feels, thinks, and behaves). Resident #1 was not identified as having any behaviors, including wandering behaviors, in the 7-day lookback period of the MDS Assessment being completed.

Review of Resident #1's Care Plan, revised 05/04/24, reflected Resident #1 was at-risk for wandering and elopement due to being disoriented to place, having a history of attempting to leave the facility unattended, and having impaired safety awareness. Resident #1 was documented to have left the facility unattended on 12/19/23. Resident #1 was documented to have removed her WanderGuard (a device worn by at-risk residents which alarmed when said resident(s) approached an exterior door in order to alert staff) on 12/22/23 and refused to have it replaced; she was then placed on the secured unit. Resident #1 was documented to have left the facility unattended for a second time on 05/04/24. Goals for Resident #1 included maintaining the resident's safety. Interventions for this goal included Resident #1 being placed on the secured unit, providing reorientation to her surroundings and environment, providing her with clear and simple instructions, monitoring her for fatigue and weight loss, and providing structured activities.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Provider Investigation Report, dated 12/22/23, reflected on 12/19/23 at 5:53PM, Resident #1 pushed on the exterior egress door at the front of the building. The door released after 15 seconds, and Resident #1 walked next door to the retirement community and knocked on an apartment door. The individual who answered the door called the police department. Resident #1 was brought back to the facility at around 6:20PM without incident. She sustained no injuries as a result of the elopement. All appropriate parties were notified, including Resident #1's family and physician. The facility's investigation revealed the exterior egress door at the front of the building, as well as the magnetic door lock, were functioning properly. Cognitive screening indicated she was sustaining a natural progression of her diagnosis of Alzheimer's disease and unspecified dementia. Her care plan was reviewed and updated. She was moved to the secured unit after an attempt at utilizing a WanderGuard was unsuccessful. Facility staff were in-serviced on abuse/neglect and the facility's elopement policy. Review of the facility's Provider Investigation Report, dated 05/10/24, reflected on 05/04/24 at 12:30AM, Resident #1 pushed on the exterior egress door of the memory care unit. The door released [after 15 seconds], and Resident #1 exited the building. Facility staff responded to the door alarm and did not see any residents outside. A head count was conducted, and it was noted that Resident #1 was not in her room or the immediate vicinity. Facility staff began searching for Resident #1; the Director of Nursing was notified, and the police department was contacted for additional assistance. Police located Resident #1 on 05/10/24 at approximately 1:00AM and brought her back to the facility without incident. She sustained no injuries as a result of the elopement. All appropriate parties were notified, including Resident #1's family and physician. Her care plan was reviewed, her elopement assessment was updated, an a medication evaluation and adjustment was completed by her psychiatrist. Facility staff were in-serviced on abuse/neglect and the facility's elopement policy/quick response time. Observation of the exterior egress door of the front of the building (where Resident #1 eloped the first time) and the exterior egress door of the secured unit (where Resident #1 eloped the second time) on 07/25/24 at 10:05AM revealed both doors led out to the front of the building. There was a 2-way (4-lane) street located approximately 100 feet in front of these doors. Observation of Resident #1 on 07/24/24 at 9:53AM revealed she was lying in her bed, which was located on the secured unit at the facility. She was clean, well-groomed, and appropriately dressed. She was free from any odors. She displayed no obvious signs or symptoms of distress. There were no concerning marks or bruises noted on her person. There were no noted concerns regarding her appearance. During an attempted interview with Resident #1 on 07/24/24 at 9:53AM, it was noted that Resident #1 was pleasantly confused and was unable to participate in a reliable interview due to cognitive impairment. However, she reported that she had never left the facility by herself before, because that would be dangerous, and, as she stated, I'm not a dangerous person. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews with Administrator A on 07/24/24 at 10:35AM and 2:03PM, she stated when Resident #1 initially admitted to the facility, she resided with the general population in the unsecured area of the facility. Resident #1 had a history of confusion but had not been identified as an elopement risk. On 12/19/23, the facility hosted an activity in which a musical group performed for a holiday celebration. After the musical group left the facility, the front exterior door was confirmed to be adequately secured and all staff disbursed to their assigned workstations. Resident #1, who was noted to have thought one of the performers was her child, pushed on the front exterior egress door of the building. The alarm sounded and after the door unlocked (following the 15-second delay), she exited and eloped from the facility. Facility staff heard the alarm sound, identified Resident #1 as missing from the facility, and went to look for her. She was brought back by police approximately twenty minutes later, after she had walked to the retirement community next door. Resident #1 returned in good spirits and was pleasantly confused. The facility attempted to place and utilize a WanderGuard anklet on Resident #1, but she cut the WanderGuard anklet off. Because of this, Resident #1's family was agreeable to place her in the secured unit. Resident #1 had resided on the secured unit of the facility since that time. On 05/04/24 at approximately 12:30AM, Resident #1 eloped from the exterior egress door of the secured unit. There were two staff members assigned to the secured unit that shift, RN B and CNA C. Administrator A reported that RN B was documenting at the Nurse's Station directly outside of the secured unit (within the same area of the general population at the facility) due to having issues with the computer located in the secured unit. CNA C was conducting resident rounds. When Resident #1 eloped from the secured unit, she pushed on the handle of the exterior egress door, which sounded an alarm and subsequently opened after 15 seconds. RN B and CNA C reportedly heard the alarm sounding, but by the time they got to the door they did not see any residents who had left. A head count was conducted, and Resident #1 was identified as missing. Facility staff immediately began to search for her, and the police and administrative staff were notified. Resident #1 was found by the police and brought back to the facility approximately 20-25 minutes after she had eloped from the building. Administrator A stated she was not sure exactly where Resident #1 was located; the facility had requested the police report, but it was never received. Resident #1 sustained no injuries but was confused; she stated she believed her children were going to steal her money, so she was trying to go to the bank to withdraw money from her account. Administrator A said it was noted that Resident #1's family memebers had visited at the facility earlier on 05/05/24 and she became increasingly confused following their visit. Administrator A stated the facility's interventions included updating Resident #1's care plan and ensuring she received frequent monitoring, which she reported did not entail line-of-sight supervision but making sure staff always knew where she was located. The surveyor requested any documentation available for the frequent monitoring as described, but no such documentation was provided. Administrator A stated the facility's expectation was for a staff member to be physically present on the secured unit at all times. She stated the risk of a resident being able to elope from the facility included potential injury. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview with CNA C (no longer employed by the facility) on 07/24/24 at 11:56AM, she stated she was assigned to care for Resident #1 when Resident #1 eloped from the secured unit on 05/04/24. CNA C stated in addition to being assigned to care for the residents on the secured unit that shift (approximately 15 residents), she was also assigned to care for several residents outside of the secured unit, within the area of the general population at the facility. She said this was common practice when she worked for the facility. CNA C stated when she arrived for her shift around 10:00PM on 05/04/24, she noted Resident #1 was asleep in her bed. That was the last time she saw Resident #1 prior to her elopement. She said when Resident #1 eloped from the secured unit, neither she nor the Charge Nurse assigned to work the secured unit (RN B) were physically present on the secured unit. CNA C said she was providing care for one of the residents outside of the secured unit and did not hear the exterior egress door alarm sound when Resident #1 pushed on the door and subsequently exited the facility. CNA C said she heard the alarm sounding when she exited the room of the resident whom she was providing care for, and following a head count, Resident #1 was identified as missing. All facility staff were notified and a search of the interior and exterior areas of the building were conducted. Police were also notified; they were the individuals who located Resident #1 and brought her back to the facility. Resident #1 did not sustain any injuries due to the elopement. CNA C stated she attempted to watch Resident #1 more closely following her elopement, but that no changes in staffing assignments were made. She said it continued to be common practice for the night shift staff who were assigned to work on the secured unit to also have residents to care for outside of the secured unit. CNA C said, I didn't really understand that [regarding the staffing], because people can get out. CNA C stated she had been made aware of Resident #1's previous elopement from the facility when she lived in the general population (12/19/23); that was the reasoning for Resident #1 being moved to the secured unit. During interviews with the Director of Nursing on 07/24/24 at 12:37PM and 1:40PM, he stated he was responsible for creating staffing assignments. He said on the 10:00PM-6:00AM shift, the secured unit was staffed with one Charge Nurse and one CNA. These staff members were also assigned to care for up to four residents outside of the secured unit, dependent upon the facility's census. He said the Charge Nurse and the CNA who were assigned to work on the secured unit as well as within the general population were responsible for making sure there was always a staff member present on the secured unit. He stated this was between the staff members to coordinate and ensure. The Director of Nursing stated the risk of a resident being able to elope from the facility was that anything can happen if they get outside. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview with RN B on 07/24/24 at 2:40PM, she stated she was assigned to care for Resident #1 when Resident #1 eloped from the secured unit on 05/04/24. RN B stated in addition to being assigned to care for the residents on the secured unit that shift, she was also assigned to care for several residents outside of the secured unit, within the area of the general population at the facility. At the time Resident #1 eloped from the facility, RN B stated she was documenting on a computer, at a Nurse's Station directly outside of the secured unit. RN B stated the other staff member who was assigned to work with Resident #1 that night, CNA C, was providing care in another resident's room. RN B stated she heard the alarm sound when Resident #1 pushed the exterior egress door, but she thought the alarm was coming from a different location. She checked the other location and did not see anything suspicious, so she went inside of the secured unit to check that door. Again, she did not see anything suspicious and did not note any residents outside. A head count was conducted and Resident #1 was identified as missing. All facility staff were notified and a search of the interior and exterior areas of the building were conducted. Police were also notified; they were the individuals who located Resident #1 and brought her back to the facility. Resident #1 did not sustain any injuries due to the elopement. RN B stated it was noted that Resident #1 had become increasingly confused after her family had visited with her that day; staff were advised to keep a close eye on her following family visits; however, no specific instruction or documentation requirements were given for this type of monitoring. RN B stated the risk of a resident being able to elope from the facility was that there was a road nearby the exterior doors of the building. Review of the facility's Wandering and Elopements policy, dated 03/2019, reflected, .The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents . An Immediate Jeopardy (IJ) was identified on 07/24/24 at 4:19PM. The IJ template was provided to the facility on [DATE] at 4:45PM and signed by Administrator A. A Plan of Removal was requested at that time. The facility's Plan of Removal was accepted on 07/25/24 at 12:29PM and reflected the following: .Corrective Action: DON/Administrator has been re-educated on Change of Condition/Elopement/Wandering/Accidents/ Hazards/Supervision by Clinical Nurse Consultant, RN 7/24/24. Effective 7/24/24: Staff schedule will change on the secured unit from 2 staff to 3 staff; new staff pattern is 2 c.n.a.'s and 1 charge nurse, on the 10 pm - 6 am shift. Additional c.n.a. was added to the schedule for 7/24/24 for the secured unit on the 10 pm to 6 am shift. Director of nursing/designee is responsible for staffing schedule for all shifts, including the night shift. Verified per DON that he spoke to LVN charge nurse on the night shift 7/24/24 and there were a total of 3 staff; 2 c.n.a.'s and 1 charge nurse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675840	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2024
NAME OF PROVIDER OR SUPPLIER Arden Place of Richland Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 7146 Baker Blvd Richland Hills, TX 76118	

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Direct care staff were educated starting 7/24/24 about new staffing pattern and the expectation that either the c.n.a. or the charge nurse is to sit at the nurse desk at all times on the night shift to monitor the doors. Unlicensed staff will be obtained to sit at the desk should there be issue with direct care staff availability to ensure all doors on the secured unit are monitored during the night shift. Administrator/designee to verify new staff schedule and adherence to the plan is in place by daily review of schedule effective 7/24/24. Any areas of non-compliance will be immediately addressed by administrator/designee. Training: All staff to receive training 7/24/24 requiring responsibility of sitting at the desk at all times on the night shift. All staff to receive training 7/24/24 regarding effective communication between staff to ensure doors are secure. All staff to receive training 7/24/24 regarding change of condition and reporting appropriately/elopement/ wandering. Director of Nursing/designee to provide training to direct care staff 7/24/24. DON/designee to provide training to all direct care staff prior to their next scheduled shift to be completed by 7/25/24. Training started 7/24/24. All education to be completed by 7/25/24. Residents affected: All residents residing on the secured unit have the potential to be affected. Affected resident had elopement assessment completed by the charge nurse 5/4/24. Care plan was reviewed, changes made as indicated. Stat labs/ua ordered/care plans reviewed. Updated elopement risk assessment. Residents residing on the unit had elopement risk assessments completed by charge nurse. All residents who have been identified in the facility as an elopement risk has had a new assessment completed by their charge nurse according to the assessment schedule. Identified resident returned to facility; no injury noted upon return. RP and medical director notified. Systemic Changes: (continued on next page)

Printed: 10/31/2024
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NAME OF PROVIDER OR SUPPLIER Arden Place of Richland Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 7146 Baker Blvd Richland Hills, TX 76118	

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff pattern has been changed on the night shift from 2 direct care staff to 3 direct care staff effective 7/24/24. This will include 2 c.n.a's and 1 charge nurse. Staffing pattern will continue 7 days a week, ongoing. Unlicensed staff will be obtained to sit at the desk should there be issue with direct care staff availability to ensure all doors on the secured unit are monitored during the night shift. Administrator/designee to verify new staff schedule and adherence to the plan is in place by daily review of schedule and validation from Director of Nursing effective 7/24/24. DON/designee to review staffing schedule and report findings to the administrator/designee daily. Maintenance director to continue to provide test operations of doors, locks and alarms every week and document in TELS. All direct care staff to be educated prior to next scheduled shift. To be completed by 7/25/24. All direct care new hires will receive this training upon hire as part of their new employee orientation. Monitoring: DON/designee to monitor staffing daily effective 7/24/24; verification to be provided to Administrator/designee. DON to report any areas of non compliance to the Administrator/designee immediately. Any areas of non-compliance will be addressed immediately by the DON/Administrator. Administrator/designee to review daily staffing daily ongoing and report findings and any areas of non-compliance to the QAPI committee. Maintenance director/designee to provide the results of test operations of doors, locks and alarms to the monthly QAPI committee. Results/findings to be provided to the monthly QAPI committee going forward. QAPI committee meeting conducted 7/24/24. Medical director has been notified as of 7/24/24 . The facility's implementation of the Plan of Removal was verified through the following: Observation of the secured unit on 07/25/24 at 4:33AM (10:00PM-6:00AM, night shift) revealed three staff members were assigned to work the unit, including one staff member who was sitting at and monitoring the exterior egress door on the secured unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675840	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arden Place of Richland Hills	7146 Baker Blvd Richland Hills, TX 76118

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews with multiple staff members who represented all departments and all assigned shifts (CNA D, CNA E, CNA F, CNA G, CNA H, CNA I, CNA J, CNA K, CNA L, CNA M, CNA N, LVN O, LVN P, LVN Q, RN R, [NAME] S, Housekeeper T, and the Dietary Manager) between 07/25/24 at 4:35AM and 07/26/24 at 2:30PM, they each reported being in-serviced on topics including changes of condition, elopement/wandering prevention and response, accident hazards, resident supervision, and the facility's new staffing pattern and expectations for the secured units. These staff members were able to verbalize the facility's policies and procedures related to the aforementioned areas, as well as how they would respond to resident changes of condition, residents who were wandering, missing residents, etc. These staff members appeared knowledgeable on the facility's policies and procedures. They each verbalized being aware that the facility had increased staffing on the secured unit during the night shift, and they all reported being aware of the expectation that a designated staff member was to sit at and monitor the exterior egress door. These interviews were conducted without incident or concern regarding the trainings provided. During interviews with Administrator A and the Director of Nursing on 07/25/24 between 12:15PM and 12:40PM, they reported being in-serviced on topics including changes of condition, elopement/wandering prevention and response, accident hazards, resident supervision, and the facility's new staffing pattern and expectations for the secured units. It was reported the Director of Nursing was to monitor staffing daily, and verification would be provided to Administrator A who would complete daily reviews. Any areas of non-compliance would also be reported to Administrator A, who would immediately address these areas. Administrator A and the Director of Nursing reported a QAPI meeting had been conducted on 07/24/24, and any results/findings related to facility staffing would continue to be discussed at monthly QAPI meetings. During an interview with the Maintenance Director on 07/26/24 at 12:25PM, he stated he had verified all exterior egress doors, magnetic locks, and alarms were in proper working order as of 07/24/24. He said he would continue to test these systems weekly and document the results, as well as notify Administrator A and the Director of Nursing of any issues. Review of in-service logs, dated 07/24/24, reflected facility staff members had been in-serviced on areas including changes of condition, elopement/wandering prevention and response, accident hazards, resident supervision, and the facility's new staffing pattern and expectations for the secured units. The Administrator was notified the IJ was removed on 07/26/24 at 1:04PM, however the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of pattern due to the facility still monitoring the effectiveness of their Plan of Removal.