

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 09/10/2024
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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747</p> <p>Based on observation, interview, and record review, the facility failed to protect the confidentiality of personal health care information for two of six (Resident #6 and Resident #65) residents reviewed for confidentiality of records.</p> <p>The facility failed to ensure LVN F locked and closed the laptop during a medication pass, which exposed Resident #6's personal information to include some of his medication orders.</p> <p>The facility failed to ensure LVN A locked the computer prior to leaving the Nurse's Station, which exposed Resident #65's personal information to include some of her diagnoses.</p> <p>This failure could affect residents by placing them at risk for loss of privacy and dignity.</p> <p>Findings included:</p> <p>Review of Resident #6's Face Sheet, dated 09/10/24, reflected he was an [AGE] year-old male, who admitted to the facility on [DATE], with diagnoses including dementia (a general term for a range of conditions that cause a decline in cognitive functioning, such as thinking, remembering, and reasoning), schizoaffective disorder/bipolar type (a mental health condition that combines schizophrenia and bipolar disorder - people with this condition experience both manic episodes and depressive episodes, along with psychotic symptoms like hallucinations and delusions), major depressive disorder (a mental health condition that can cause a persistent low mood and loss of interest in activities that were once enjoyable), and type 2 diabetes mellitus (a chronic disease that occurs when the body doesn't make enough insulin or doesn't use it properly, resulting in high blood sugar levels).</p> <p>Review of Resident #65's Face Sheet, dated 09/10/24, reflected she was a [AGE] year-old female, who admitted to the facility on [DATE], with diagnoses including major depressive disorder (a mental health condition that can cause a persistent low mood and loss of interest in activities that were once enjoyable), type 2 diabetes mellitus (a chronic disease that occurs when the body doesn't make enough insulin or doesn't use it properly, resulting in high blood sugar levels), and alcoholic cirrhosis of the liver with ascites (a condition that occurs when a person has a buildup of fluid in their abdomen due to cirrhosis of the liver, which is often caused by drinking too much alcohol).</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 09/08/24 at 9:12AM revealed the computer screen on LVN F's medication cart was unlocked and unsupervised for approximately 1-2 minutes while LVN F was down the hallway. Resident #6's personal information, including medication orders, was exposed to staff, residents, and visitors who were present on the hall.</p> <p>Observation on 09/08/24 at 9:14AM revealed the computer screen at the Nurse's Station in which LVN A was assigned was unlocked and unsupervised for approximately 1-2 minutes while LVN A was providing care in a resident's room. Resident #65's personal information, including some of her diagnoses, was exposed to staff, residents, and visitors who were present on the hall.</p> <p>During an interview with LVN F on 09/08/24 at 9:20AM, she stated she did not know why she left the computer screen unlocked and unsupervised. She stated she had been in-serviced on the importance of maintaining the privacy and confidentiality of residents, and the computer screen should have been locked prior to walking away from the medication cart.</p> <p>During an interview with LVN A on 09/08/24 at 9:26AM, she stated there was no good reason as to why she left the computer screen unlocked and unsupervised while providing care for another resident. She stated she had been in-serviced on the importance of maintaining the privacy and confidentiality of residents, and the computer screen should have been locked prior to leaving the Nurse's Station.</p> <p>During an interview with the DON on 09/10/24 at 1:55PM, he stated facility staff were expected to maintain the privacy and confidentiality of residents, which included ensuring their personal information was not left visible to other staff, residents, and visitors. He stated the risk of staff leaving their computers unlocked with resident information visible was that individuals who were not privy to those residents' information could have access to it.</p> <p>Review of the facility's Confidentiality of Information and Personal Privacy policy, dated 08/2024, reflected, . the facility will safeguard the personal privacy and confidentiality of all resident personal and medical records .</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193</p> <p>Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for one of thirteen resident (Resident # 74) reviewed for ADLs.</p> <p>The facility failed to provide Resident #74 with ADL care (incontinent care).</p> <p>This deficient practice could place residents who required extensive assistance with ADLs at risk of not receiving care and services needed to maintain quality of life and prevent decline in their mental and psychological wellbeing.</p> <p>Finding included:</p> <p>Record review of Resident #74's face sheet revealed she was [AGE] year-old female admitted to the facility on [DATE]. Resident's diagnoses included, dementia, essential hypertension, muscle wasting and atrophy, muscle weakness and need for assistance for personal care.</p> <p>Record review of Resident #74's significant change in status MDS dated [DATE] revealed her Brief Interview for Mental Status (BIMS) was a 6 out of 15 revealing cognitive impairment. Her ADL status revealed she needed limited assistance of one person for bed mobility, total dependence of one staff for toilet use. Resident #74 was always incontinent of bladder.</p> <p>Record review of Resident #74's care plan revised 05/02/24 reflected, Focus . (Resident #74) has bladder incontinence r/t cognitive deficit and impaired mobility. Goal, the resident will remain free from complications r/t incontinence such as UTIs through the review date. Intervention . Monitor for incontinence. Wash, rinse and dry the perineum. Monitor for incontinence and provide incontinent care or barrier cream as needed.</p> <p>Observation on 09/10/24 at 02:02 PM revealed Resident #74 was in bed, and the aide was providing care. The aide started providing care after positioning the resident. The resident was soiled with urine, also the linens were soiled with urine and the fitted sheet had a ring of urine around where the resident was lying. Initially the staff cleaned the resident and applied the clean brief, and when the surveyor was asked if the linens were wet that was when the aide stated the linens were wet and removed the linens and then the resident stated, I am soaking wet. No indication of skin breakdown.</p> <p>In an interview on 09/10/24 at 02:08 PM with CNA B she stated she had checked the resident early and the resident was dry, but she did not specify what time.</p> <p>In an Interview on 09/10/24 at 02:09 PM with Resident #74 she stated while the CNA B was in the room that she had not been changed since the night before. Resident #74 stated CNA B had assisted her with her breakfast, but CNA B did not check if she was wet. Then the resident stated the aide might have been busy taking care of other residents. After the resident stated she had not been changed since last night, then CNA B stated she was busy, and she was not able to change the resident throughout the shift. CNA B stated she was expected to check the resident routinely and provide incontinent care to prevent skin breakdown and making sure the resident was well groomed.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 09/10/24 at 02:32 PM with the DON he stated he expected CNA B to complete and assist the resident with her ADLs care. The DON stated he expected Resident #74 to be provided with incontinent care routinely to prevent skin breakdown and maintain resident's dignity. The DON stated he was responsible and the charge nurses to check and make sure the residents are changed and ADLs cares completed timely.</p> <p>Review of the facility policy revised March 2018, titled Activities of Daily Living (ADLs) Supporting, reflected, Residents will be provided with care, treatments, and services to maintain or improve their ability to carry out activities of daily living (ADLs).</p> <p>Residents who are unable to carry out activities of daily living independently will receive services necessary to maintain good nutrition, grooming and personal and oral hygiene.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable for 1(Resident #67) of 3 residents reviewed for pressure ulcers.</p> <p>The facility failed to prevent the development of a pressure ulcer for Resident #67.</p> <p>This failure placed residents at risk of delayed identification/treatment of injuries, worsening of injuries, pain, and infection.</p> <p>Findings Include:</p> <p>Record review of Resident #67's face sheet dated 09/10/24 revealed, an [AGE] year-old female who admitted to the facility originally on 01/05/23 and readmitted on [DATE] with the following diagnoses which included; dementia, essential hypertension, protein calorie malnutrition and muscle weakness</p> <p>Record review of Resident #67's Quarterly MDS dated [DATE] revealed, severely impaired cognition as indicated by a BIMS score of 00 out of 15, total dependence with most ADL's, total dependence with most functional abilities including shower/bathe self, upper body dressing, substantial/maximal assistance (helper does more than half the effort) assistance with personal hygiene (includes washing and drying hands). The resident was at risk for developing pressure ulcer/injury.</p> <p>Record review of Resident #67's care plan revised 03/21/24 revealed, Focus: [Resident #67] has potential for impairment to skin integrity/pressure ulcer development r/t impaired mobility requiring assist, nutritional deficits and incontinence of B/B.Goal, The resident will have no evidence of skin breakdown noted through the review date.Intervention, .Complete weekly skin assessment. Encourage good nutrition and hydration in order to promote healthier skin</p> <p>Review of the physician's order dated 09/10/24 for the month on September (2024) reflected, Clean area to L back of the ear, pat dry, apply skin prep daily. everyday shift for Maintain skin integrity, order date 09/09/24. Clean underneath left ear with normal saline pat dry and apply TAO for 5days . every day shift, order date 09/09/24. Assess bilateral back of the ears daily, ensure ear protectors are in place, document/report any skin breakdown as indicated every shift for Maintain skin integrity.</p> <p>Observation on 09/09/24 at 01:14 PM during wound care revealed Resident #67 was in bed. LVN D completed wound care on Resident #67's left heel, right heel, right buttock and behind the right knee. During care the resident reported pain but declined to take pain medication. The times when the resident was being positioned on the left side, she reported pain to her ear. Resident #67 was using oxygen via nasal cannula and the tubing was behind her ears. The Surveyor asked LVN D if she could assess the resident's ears and on assessment the resident was noted with a wound behind the left ear. There was some drainage and hair were attached on the drainage that had already dried.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 09/09/24 at 02:05 PM with LVN D, who was completing the wound care, she stated she had taken care of the resident last on Friday (09/06/24) and she did not assess the resident's ears because she did not think she had any wounds to her ear. LVN D stated today was when she noted the wound after the resident complained of ear pain. LVN D stated the resident was supposed to have ear protectors to prevent the skin breakdown, she noted the tubing pulling on the ears. LVN D stated the charge nurses were to assess the resident ears periodically (no specific time provided) for any skin breakdown due to the use of oxygen tubing. LVN D stated not being aware of the resident having a wound could result to the wound getting worse and getting infected. LVN D stated she would inform the resident's primary care provider of the new wound.</p> <p>In an interview on 09/09/24 at 02:43 PM with RN E, she stated she took care of Resident #67 last week, and she did not notice the open area behind the resident's ear, and she did not assess the resident's ears. RN E stated she completed wound care rounds with the wound care Dr, and there were no reports of the resident having any wounds to her ear. RN E stated the charge nurse were responsible to assess the resident's ears for any skin breakdown frequently. RN E stated wounds that were not addressed timely could lead to wound infection and wounds getting worse.</p> <p>Observation on 09/10/24 at 11:21 AM of an assessment with RN E revealed Resident #67 had an open area on the back of the left ear, no drainage, open to air, wound bed was red, and there were no signs or symptoms of infection. RN E stated the resident was assessed by the primary care provider on 09/09/24 and gave new orders for treatment for five days. The nurse stated the nurses were to assess the resident ear's daily and make sure the resident had the protective foam on the oxygen tubing to prevent any skin breakdown.</p> <p>In an interview on 09/10/24 at 02:05 PM with the DON he stated he was not aware Resident #67 had a wound to the left ear. The DON stated per the skin assessment completed on 09/02/24 the resident did not have any skin issues. The DON stated the</p> <p>nurses were responsible to monitor for the resident's skin breakdown and inform the resident's primary care provider and follow the orders. The nurses should assess the resident ears since she had oxygen tubing to make sure the resident was not having skin breakdown. The DON stated lack of wound care could lead to the wound getting worse and the wound getting worse.</p> <p>Review of the facility policy revised 10/2020, titled Wound care reflected, Purpose. This procedure provides guidelines for the care of wound care to promote healing.</p> <p>Facility did not have a policy regarding addressing new wounds.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193</p> <p>Based on observation, interview, and record review the facility failed to ensure each resident received assistance devices to prevent accidents for 1 (Resident #19) of 2 Residents who were observed for transfers.</p> <p>LVN A failed to use the gait belt as needed due to the resident having unsteady gait while repositioning Resident #19 in the wheelchair.</p> <p>The deficient practices could affect residents who require assistive devices during transfers and could contribute to avoidable falls.</p> <p>The findings were:</p> <p>Review of Resident #19's face sheet, dated 09/10/24, revealed she was admitted to the facility on [DATE] with some of the diagnoses including history of falling, repeated falls, muscle wasting and atrophy and muscle weakness.</p> <p>Review of Resident #19's quarterly MDS assessment dated [DATE] revealed her BIMS was 10 reflective of mild cognitive impairment; had a history of fall after admission and required maximum assistance from sitting to standing.</p> <p>Review of Resident #19's Care Plan, revised 2/26/24, revealed, Focus, (Resident 19) has HX of falls and remains at risk for falls r/t impaired mobility/balance, unsteady gait, . Goal, The resident will be free from falls through the review date.</p> <p>Observation on 09/08/24 at 02:15 PM revealed Resident #19 was in the wheelchair, family was in the room, and the family member stated the resident had said she was having pain in her back, and she was not sat well in the wheelchair. The resident's family member left the room and came back with LVN A. LVN A was observed lifting Resident #19 from the wheelchair by putting her arms below the resident's arm. The resident's family member assisted pulling the resident's pants in position, and then LVN A assisted Resident #19 to sit back in the wheelchair.</p> <p>In an interview on 09/08/24 at 02:37 PM with LVN A she stated, she was aware she did not use the gait belt because she was old school. LVN A stated per the facility policy she was supposed to use the gait belt, but she did not have one with her because normally she did not do transfers. LVN A stated gait the belt was required to transfer the resident to prevent falls or harming the resident because it could cause a fracture.</p> <p>In an interview on 09/10/24 at 02:34 PM with the DON, he stated per the facility policy, staff were required to use a gait belt while assisting the resident with a transfer. The DON stated the staff should have the gait belt with them and some of the gait belts were in the residents' rooms. The DON stated staff were supposed to use a gait belt to prevent harm through falls or causing any fracture on the residents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy revised July 2017, titled Safe Lifting and Movement of Residents, reflected, In order to protect the safety and well-being of staff and residents and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents.4. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. 5. Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>42283</p> <p>Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation.</p> <p>The facility failed to ensure food was properly stored in the facility's kitchen.</p> <p>The facility failed to ensure food on the steam table reached the appropriate temperature before plating food for resident consumption.</p> <p>This failure could place residents at risk for food-borne illness.</p> <p>Findings Included:</p> <p>Observation of the facility's refrigerator on 09/08/24 beginning at 9:20 AM revealed:</p> <ul style="list-style-type: none"> - 6 cucumbers with fuzzy white spots; - 3 cut tomatoes in a box open and exposed to air; - 1 onion with black spots; - 7 withered tomatoes; - 1 bag of shredded lettuce with brown lettuce leaves; - 1 bucket of pork chops thawing on the second shelf above eggs; - 1 box of bacon open and exposed to air; - individually wrapped sandwiches cut in half with no date; - pasta salad with no date; - 2 green bell peppers with black spots; - 4 withered green bell peppers; and - 1 bag of shredded cheese open and exposed to air. <p>Observation of the facility's freezer on 09/08/24 beginning at 9:51 AM revealed:</p> <ul style="list-style-type: none"> -1 box of cut green beans open and exposed to air; and <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- 1 box of green peas open and exposed to air.</p> <p>Observation of the facility's dry storage in the kitchen on 09/08/24 beginning at 10:12 AM revealed:</p> <p>-1 bag of macaroni noodles open and exposed to air.</p> <p>Observation of the facility's seasoning shelf on 09/08/24 beginning at 10:21 AM revealed:</p> <p>-1 container of onion powder open and exposed to air; and</p> <p>- 1 container of quick creamy wheat open and exposed to air.</p> <p>Observation of the facility's steam table on 09/10/24 beginning at 11:46 am revealed the pork loin reached 131 degrees Fahrenheit. The dietary staff plated approximately 20 plates of pork loin on two rolling carts. The carts were taken to the dining room to serve to residents. There were six residents served pork loin prior to Surveyor intervention. The Dietary Supervisor pulled and discarded all plates containing pork loin. The dietary staff reheated the pork loin to 150 degrees Fahrenheit.</p> <p>In an interview with the Dietary Supervisor on 09/10/24 at 3:30 PM revealed she completed walk throughs of the kitchen in the morning and evening. She stated she was responsible for ensuring dietary staff were storing food properly. She stated dietary staff were supposed to label and seal foods. She stated anything in the refrigerator after three days old was thrown away. She stated she ensured staff were aware of food temperatures by posting signs and having information in the temperature log books. She stated the pork loin at a temperature of 131 degrees Fahrenheit was not supposed to be served to residents. She stated the pork loin should have been pulled and warmed up to hold a temperature of 165 degrees Fahrenheit for 15 seconds. She stated improper food storage and undercooked pork loin could cause harm to residents such as contamination and food borne illnesses.</p> <p>Record review of the facility policy titled Food Storage: Dry Storage, dated February 2023 (revised), revealed All packaged and canned food items will be kept clean, dry, and properly sealed.</p> <p>Record review of the facility policy titled Food Storage: Cold Foods, dated February 2023 (revised), revealed All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.</p> <p>Record review of the facility policy titled Food: Preparation, dated February 2023 (revised), revealed All foods will be held at appropriate temperatures, greater than 135 degrees Fahrenheit (or state regulation requires) for hot holding, and less than 41 degrees Fahrenheit for cold food holding.</p> <p>Review of the Food and Drug Administration Food Code, dated 2022 reflected, .3-305.11 Food Storage. (A) . food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193</p> <p>Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 1(Resident #74) of 8 residents reviewed for infection control in that;</p> <p>During a wound dressing change for Resident #74, LVN C did not sanitize her hands or change gloves in between removal of an old dressing and cleansing and application of a new dressing.</p> <p>The deficient practices could place residents at-risk for infection due to improper care practices.</p> <p>Findings Included:</p> <p>Record review of Resident #74's face sheet revealed she was [AGE] year-old female admitted to the facility on [DATE]. Resident's diagnoses included, dementia, essential hypertension, muscle wasting and atrophy, muscle weakness and need for assistance for personal care.</p> <p>Record review of Resident #74's significant change in status MDS dated [DATE] revealed her Brief Interview for Mental Status (BIMS) was a 6 out of 15 revealing cognitive impairment. Her ADL status revealed she needed limited assistance of one person for bed mobility, total dependence of one staff for toilet use. Resident #74 was always incontinent of bladder.</p> <p>Observation on 09/09/24 at 11:04 AM revealed LVN C providing surgical wound care to Resident #74. LVN C gowned and gloved and then took off the dressing from Resident #74's right toe and revealed all the right toes had been amputated and the resident had sutures on the wounds. LVN C cleaned the surgical area with normal saline and gauze, pat dried and then applied betadine and dry dressing and then wrapped with ace wrap. LVN C used the same gloves for the entire wound care and did not change gloves or complete hand hygiene.</p> <p>In an interview on 09/09/24 at 12:15 PM with LVN C she stated she forgot to change gloves and complete hand hygiene during the wound care. LVN C stated she was supposed to wash hands and change gloves and complete hand hygiene after cleaning the resident's wound to prevent the spread of infection. She stated she had received an in-service on infection control about 6months ago.</p> <p>In an interview on 09/10/14 at 01:34 PM with the DON he stated he was the infection preventionist. The DON stated the facility had in-serviced staff on hand washing and PPE on 08/28/24 with nursing staff and it was random. The DON stated he expected the staff to maintain infection control and complete hand hygiene during wound care. The DON stated he expected the staff to maintain infection control to prevent the spread of infection.</p> <p>(continued on next page)</p>		

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 09/10/2024
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy revised October 2018 and titled Infection Prevention and Control Program reflected, .3. The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of quality assurance and performance improvement program.11. Prevention of infection 8. following established general and disease-specific guidelines such as those of the Center for Disease Control (CDC)</p>		