STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675882	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Gardens of Allen	310 S Jupiter Allen, TX 75002

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for one (Resident #81) of eight residents reviewed for ADL care. 1. The facility failed to provide Resident #81 with timely incontinence care on 11/17/24. This failure could place residents at risk for a skin breakdown and infection. Findings included: Record review of Resident #81's annual MDS assessment, dated 08/08/24, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His BIMs score was 15 indicating his cognitive status was intact. His diagnoses included heart failure, cerebral palsy (group of conditions that affect movement and posture), and paraplegia (paralysis that affects the lower part of the body). The resident was dependent on staff for toileting. The resident was always incontinent of bowel and bladder. Record review of Resident #81's care plan reflected: 08/04/24 The resident had an ADL self-care performance deficit related to impaired mobility, weakness, and paraplegia. Facility interventions included resident required 1-2 persons assistance with toilet use. 09/26/24 The resident had bowel/bladder incontinence and was at risk for infection and skin breakdown. Facility interventions included brief use. Staff were to clean the peri-area with each incontinence episode. Review of Resident #81's Task Record, dated 11/17/24, reflected the resident did not have documentation showing that the resident received incontinence care on the 2:00 PM - 10:00 PM shift. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 11/18/24 at 11:20 AM with Resident #81 and his Roommate, Resident #82, revealed he was sitting up in bed. He was awake, alert, and oriented. Resident #81 and his roommate said on 11/17/24 during the 2:00 PM - 10:00 PM Resident #81 had to wait an hour and forty-five minutes to receive incontinence care. Resident #81 said he had to sit in a wet brief the whole time. Resident #81 said he pressed the call light and the nurse, name unknown, told him she did not know where CNA A was. Resident #81 said when CNA A arrived to his room, he told him that he had to take care of all the residents on his other hall before he could get to Resident #81. An interview on 11/19/24 at 1:24 PM with the DON revealed she did not know the true names of the staff who took care of Resident #81 on 11/17/24, but only knew them by their nickname which was not on the employee roster. She said she would find out, but that she had talked to Resident #81 about the issue. The DON said she was going to speak to CNA A and do in-servicing with him about call lights. She said there was not an exact amount of time that a resident should have to wait for incontinence care, but that the care should be provided in a timely manner. She said Resident #81 did not have skin breakdown and there was not a shortage of staff who had worked the shift. The DON said the CNA and nurse were responsible for ensuring residents received timely incontinence care. She said the risk to the resident who did not receive timely incontinence care was risk to the resident's safety. The DON said she was not aware that staff did not document that they provided the resident with incontinence care on the 2:00 PM - 10:00 PM shift for 11/17/24. An interview on 11/19/24 at 1:58 PM with CNA A revealed Resident #81 was on Hall 200 and he was only assigned to Hall 100. He said he had to switch a resident and that was the reason he also had Resident #81. CNA A said he did not know Resident #81 had pressed his call light. CNA A said he started making his rounds at 8:00 PM on Hall 100. He said he did not reach Resident #81's room until around 9:00 PM. He said he did not need anyone's help to do his job and he could switch and do incontinence care for Resident #81 first, but no matter what, someone was going to have to wait for care. CNA A said he did not tell LVN B to help him. He said there was not a staffing issue. He said LVN B did not tell him until after he had finished Hall 100 that Resident #81 had pressed his light. An interview on 11/19/24 at 2:13 PM with LVN B revealed she answered the call light for Resident #81 on the 2:00 PM - 10:00 PM shift on 11/17/24. She said CNA A was busy with another resident at the time she answered the call light. She said she told Resident #81 that CNA A would change him when he finished with the other resident. LVN B said Resident #81 did not tell her how long he had to wait for care. She said it was her responsibility to ensure residents received timely incontinence care. She said she did not go back to Resident #81 to make sure CNA A assisted him. Review of the facility policy, Perineal Care, revised October 2010 reflected: Purpose The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition . Documentation Care will be reflected in POC PCC .

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028 Based on observation, interview, and record review, the facility failed to ensure a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 (Resident #8) of 3 residents reviewed for pressure ulcers. The facility failed to provide wound care for Resident #8 on 11/16/24 and 11/17/24. This failure could place residents with pressure wounds at risk of the wound worsening, leading to increased pain, infection, delayed healing, serious complications including sepsis, reduced mobility, and a lower quality of life. Findings included: Record Review of Resident #8's Admission Record and MDS assessment revealed a [AGE] year-old male, readmitted to the facility on [DATE] with an original admitted [DATE]. Resident's MDS revealed a BIMS score of 14 indicating he as cognitively intact. Record Review of Resident #8's Diagnosis Report and TAR revealed the following diagnoses: Pressure Ulcer of right buttock, essential (primary) hypertension, Cerebral Infarction, Metabolic Encephalopathy, Frontal Lobe and Executive function deficit following cerebral infarction, sepsis - unspecified organism, cognitive communication deficit, muscle wasting and atrophy, other lack of coordination, muscle weakness (generalized), occlusion and stenosis of unspecified carotid artery, thrombocytosis, infection and inflammatory due to indwelling urethral catheter, myelodysplastic syndrome, osteomyelitis, morbid obesity, type 2 diabetes, generalized anxiety disorder. Record Review of Resident #8's Orders revealed the following medications: -Prostat 30ml for wound 3 times a day -PT, OT, ST to evaluate and treat as indicated -Apply Miconazole powder to scrotal/perinium area after every brief change -Apply Zinc Oxide cream to scrotal/perinium area after every brief change Record Review of Resident #8's Orders revealed the following order: Cleanse wound to right gluteal fold with wound cleanser, pat dry, apply gentamicin, apply Dakin's-soaked gauze, and secure with foam dressing- one time a day for wound care. Record Review of Medication Error Review revealed the error occurred on 11/17/24 between 6 a.m. - 2 p.m. for Resident #8. The date of report was 11/18/24. The report reveals the description of error was noticed TARS not documented on, showing missed treatment orders. The report was signed by DON, ADON, and Nurse #1 on 11/18/2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Resident #8's Progress Notes revealed no progress notes entered for the dates of 11/16/2024 and 11/17/2024. Record Review of Resident #8's Pressure Wound Summary states the wound was evaluated on 11/07/2024. The dimensions of the pressure wound showed the Area as 13.45 cm, Length as 6.12 cm, and Width as 2.65 cm. Record Review of Resident #8's Skin and Wound Evaluation completed on 11/15/2024 revealed pressure wound as type of wound located on Right Ischium, present for 1-2 years. Measurements on the report stated the area as 23.8 cm, width as 7.0 cm, and depth as 3.0 cm. An interview on 11/19/2024 at 9:50 a.m. of Resident #8 revealed resident appeared to be well-groomed, clean hygiene, free from odors, and in clean appropriate clothing. Resident was alert oriented. Resident #8 reported he does not get enough help on the weekends. He stated he has a wound that the dressing needs to be changed every day. He reported his bandage was not changed on Saturday (11/16/24) and Sunday (11/17/24). He said he asked the nurse maybe a dozen times that weekend and kept getting excuses. Resident #8 reported staff told him they are going to change his bandage today. He reported during the week he has the best help; he is not sure why this has to change on the weekend. Resident #8 stated the bed sore came from a previous nursing home. He stated when it developed it progressively got worse. Resident #8 stated he has a wound care guy that comes here on Thursdays once a week to check his wounds and then in between those days the nurses treat his wounds. Resident #8 reported he was not in pain now. He stated he did not believe the wound worsened over the weekend but that the weekday staff would take care of him. On 11/20/2024 an interview with Charge Nurse #1 at 10:44 a.m., Charge Nurse, LVN. Nurse #1 stated she worked at the facility over the weekends only. She stated she is responsible for wound care and had several residents with wound care that she oversaw. Nurse #1 stated she is assigned to Resident #8. Nurse #1 stated she completed wound care on Resident #8 on 11/16/24 and 11/17/24. Nurse #1 stated according to her TAR she did complete the wound care. Nurse #1 stated if a resident does not receive wound care, they could become necrotic, very sick, and septic . Nurse #1 stated she documented the wound care. Observation and Interview of Resident #8 on 11/20/2024 at 10:19 a.m. Surveyor Nurse obtained permission from Resident #8 to observe wound care treatment provided by the ADON/ WCN. Resident #8 stated he did not receive wound care on the weekend (11/16/24-11/17/24). Resident stated he asked more than 4 times for it. Observation of wound care treatment on 11/20/2024. Resident #8 was assisted to reposition onto his left side. Right ischium with large, dark, deep, red, open area with a moderate amount of slough and skin excoriations that is painful to the resident was observed. The nurse took off the dressing and cleaned the wound. The resident stated he wanted medication for pain. The ADON stopped the wound care, and the resident was medicated. ADON was wearing correct personal protection equipment. ADON performed incontinence care to resident. ADON stated the pressure ulcer does not look much different than it did on last Thursday (11/14/24). ADON cleaned the wound, performed hand hygiene, treatment, wet to dry with Dakin's and dressing applied. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADON was asked why Resident #8 did not receive wound care over the weekend. The ADON/Wound Care Nurse stated that maybe Nurse #1 did not document the treatment on the weekend. The surveyor stated to the ADON that the resident reported not receiving the treatment at all on the weekend. The ADON stated she did not know what happened. Interview with Nurse #2 at 2:15 p.m. on 11/20/2024. Nurse #2 stated she completed wound care for Resident #8 on Friday, November 15, 2024, and Monday, November 18, 2024. Nurse #2 stated during wound care on Monday the 18th, she did not notice worsening condition of the pressure ulcer. Nurse #2 stated the bandage was so saturated that she could not see the date on the bandage . On 11/20/2024 Interview with ADON/Wound Care Nurse. The ADON reported that Nurse #2 completed Resident #8's wound care treatment on Friday 11/15/2024 and Monday, 11/18/2024. The ADON stated she and the physician complete wound care and assessments every Thursday. ADON stated the charge nurse is responsible for ensuring the wound care is done. The ADON stated she completed the follow up to make sure the treatments are done. The ADON stated she was made aware on 11/20/2024 by Resident #8 that he did not receive wound care treatment over the weekend. The ADON stated she was made aware that Nurse #1 did not document the wound care treatment and asked Nurse #1 to come to the facility on [DATE] to complete her documentation but she did not come. The ADON stated she was made aware the documentation was not completed during the morning meeting on Monday, 11/18/2024. An interview on 11/20/2024 with DON. The DON stated she was made aware on Monday this week (11/18/24) that the TAR was not completed by Nurse #1. The DON stated she pulls the TAR report every day. The DON stated once she noticed the TAR was incomplete for Resident #8 for 11/16/2024 and 11/17/2024 she then completed the medication error report. The DON stated she only asked Nurse #1 about the incomplete TAR report. The DON stated Nurse #1 told her that she did complete wound care on Resident #8 on those two days, but she did not click off on the TAR. The DON stated she did not ask Resident #8 if he received wound care on those two days. The DON stated when she reviewed the TAR, it only showed Resident #8 as not receiving wound care over that weekend. The DON stated she asked Nurse #2 what the date on the bandage on Resident #8 stated when she provided wound care on Monday, 11/18/24. The DON stated Nurse #2 told her that the bandage was too saturated she could not see the date. The DON stated she confirmed Resident #8 received wound care by asking Nurse #1 and did not ask Resident #8 if he had received wound care. The DON stated she believes Resident #8 did receive wound care over the weekend. The DON stated from dealings with the resident (Resident #8) and dealing with wound care nurses, and the amount of drainage present, the bandage would not have stayed on if it were not changed. The DON stated she does not have concerns about Resident #8 lying in the past, but Resident #8 has mentioned in the past about not receiving adequate care on the weekends. The DON stated it would have been beneficial to ask Resident #8 if he had received wound care on 11/16/24 and 11/17/24s. The DON reported that lack of wound care could lead to increased risk of infection and deterioration. The DON stated Resident #8 did not receive wound care on 11/6/24 or 11/17/24. Record Review of the facility's Wound Care Policy. The policy states the procedures for appropriate wound care. The policy states that the Purpose of the procedure is to provide guidelines for the care of wounds to promote healing. In preparation, the policy states the following: 1. Verify that there is a physician's order for this procedure. 2. Review the resident's care plan to assess for any special needs of the resident. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. For example, the resident may have PRN orders for pain medication to be administered prior to would care. 3. Assemble the equipment and supplies as needed. Date and initial all bottles and jars upon opening. Wipe nozzles, foil packets, bottle tops, etc., with alcohol pledget before opening, as necessary. (Note: This may be performed at the treatment cart.) Additionally, the policy states the following regarding documentation: The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The name and title of the individual performing the wound care. 4. Any change in the resident's condition. 5. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 6. Any problems or complaints made by the resident related to the procedure. 7. If the resident refused the treatment and the reason(s) why. 8. The signature and title of the person recording the data. 51181