STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675905	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Birchwood of Grapevine		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Autumn Drive Grapevine, TX 76051	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to treat each resident with respect, dignity, and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 2 (Residents #22 and #47) of 3 residents reviewed for dignity. RN D failed to maintain Resident #22 and #47's dignity and respect by standing between the residents while feeding both of them during lunch time on 08/27/24 at 12:17 PM . The failure could negatively affect the mental and psychological well-being of all residents who required the assistance of staff with eating. Findings included: Record review of Resident #22's face sheet dated 08/29/2024 reflected the resident was an [AGE] year-old male admitted to the facility on [DATE] with diagnosis of Alzheimer's disease (most common type of dementia), lack of coordination, dysphasia (language disorder marked by deficiency in the generation of speech), and cognitive communication deficit (difficulty thinking and how someone uses language). Record review of Resident #22's Quarterly MDS assessment dated [DATE] reflected the resident had severe cognitive impairment with a BIMS score of 03 with short- and long-term memory problems. The MDS reflected the resident required partial to moderate assistance with eating. Record review Resident 22's care plan revised 07/02/2024 reflected: has a significant unplanned/unexpected weight loss poor food intake. Interventions: Provide hands on assistance during meals. Record review of Resident #47's face sheet dated 08/29/2024 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis of Alzheimer's disease, lack of coordination, dysphasia, cognitive communication deficit, and dementia (loss of cognitive functioning impacting daily life and activities). Record review of Resident #47's Significant Change MDS assessment dated [DATE] reflected a BIMS score of 0 indicating the resident had severe cognitive impairment. The MDS reflected the resident was dependent on staff for eating. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review Resident #47's care plan dated 12/23/2023 reflected the resident had an ADL self-care performance deficit related to eating, and she was totally dependent upon one staff to assist her with eating. Observation on 08/27/2024 at 12:17 PM revealed RN D stood between Residents #22 and #47 in the dining room. She alternately fed each resident from their respective plates of food while standing. Interview on 08/27/2024 at 2:45 PM, RN D stated she did not see anything wrong with feeding both residents while standing. She stated if she had seen a chair she would have sat down; however, since there was none, she decided to stand. RN D stated she did not know why she should sit while feeding resident. She stated it helped to slow down the feeding. She stated she was not aware of the risk of standing while assisting with feeding, and she had not done training on dignity. Interview and record review on 08/29/2024 at 3:00 PM, the DON stated she expected staff to sit next to residents and be on the same level when assisting them to eat. She said this respected their dignity by promoting a respectful environment and prevent aspiration. She said staff needed to be mindful of residents' dignity. She said staff were trained on resident rights and dignity. She provided a copy of an in-service record covering the topic of dignity dated 08/23/2024, and RN D's name was not documented as being an attendee of the training. The in-service training record reflected: Ensure all residents are shown dignity you always sit down while feeding residents. Interview on 08/29/2024 at 3:04 PM, the ADON stated she expected staff to sit while feeding residents. She said the staff needed to be sure they paid attention to the residents to ensure their needs were met while eating. She stated the staff should be face-to-face to prevent shock and food spilling on residents. She said staff had been trained on resident dignity. Record review of the facility's Resident Rights policy, revised February 2022, reflected: .All residents have a right to: a. Dignified existence, b. Be treated with respect, kindness, and dignity. .e. Self-determination, f. communication with and access to persons and services inside and outside the facility. The Facility must and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on interview and record review, the facility failed to ensure the residents' rights to formulate an advance directive for 1 of 18 residents (Resident #239) reviewed for advanced directives. The facility failed to ensure Resident #239's code status (advance directives) was accurate and consistent with all records at the facility and did not provide information to the resident related to her right to formulate an advance directive. This failure placed residents at risk of not having their end of life wishes honored. Findings included: Record review of Resident #239's face sheet dated [DATE] reflected the resident was a [AGE] year-old female admitted on [DATE]. Record review of Resident #239's Admission MDS assessment dated [DATE] reflected the resident was cognitively intact with a BIMS score of 15. The resident's diagnoses included multiple sclerosis (chronic disease of the central nervous system), anxiety disorder (mental health disorder) and hyperkalemia (high potassium). Record review of Resident #239's care plan dated [DATE] reflected there was not a care plan addressing the resident's code status or advanced directives. Record review of Resident #239's physician order summary report dated [DATE] reflected it did not have an active physician's order regarding the resident's elected code status, such as full code status or any other order to support her advance directive. Record review of facility Order List Report dated [DATE] located in the facility's emergency crash cart reflected Resident #239 was not on the list for code status. Interview on [DATE] at 10:24 AM with Resident #239 revealed she admitted to the facility about two weeks ago. Resident #239 stated she had not been asked about her code status. She stated her preference would be DNR. Interview and record review on [DATE] at 10:35 AM with LVN K revealed she was the nurse assigned to Resident #239. She stated when a resident admitted to the facility, it was the responsibility of the admission nurse to ask the resident for their code status and document it in the resident's chart. LVN K stated it was the responsibility of the Social Worker to follow-up with the resident and include the code status in the resident's care plan. LVN K reviewed Resident #239's clinical records and stated she was not aware Resident #239 did not have a physician order for code status or that it was not documented in the resident's care plan. Record review of Resident #239's physician order summary report dated [DATE] reflected a physician order for Full Code. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 10:56 AM, the Social Worker stated it was the responsibility of the admission nurse to ask residents about their code status. She stated she would follow-up shortly after their admission. She stated once she obtained the resident's code status it was her responsibility to care plan it. She stated she was not aware Resident #239's code status was not documented in the resident's chart. She stated the code status should be in PCC (electronic health record system) under the physician orders and care plan. She stated Resident #239's code status was Full Code, and she forgot to care plan Resident #239's code status. She stated the risk of not having a code status would be doing CPR or not doing CPR. Interview on [DATE] at 2:46 PM, the ADON stated it was the responsibility of the admission nurse to obtain and document code status. She stated she was not aware Resident #239 did not have a code status until today ([DATE]) when LVN K informed her. She stated it was the responsibility of the social worker to follow up when she completes her code status audits. The ADON stated code status should be care planned which were completed by the social worker. She stated the potential risk of not having code status would be confusion during an emergency. Interview on [DATE] at 3:23 PM, the DON stated advance directives were obtained upon a resident's admission to the facility by the admitting nurse. She stated the Social Worker would then follow-up with the resident. She stated she was not aware Resident #239 did not have a code status. She stated she was informed today ([DATE]). She stated she expected her nurses to obtain residents' code statuses upon admission, and she expected the Social Worker to follow-up and care plan the code status. She stated code status should be documented in PCC and on the care plan. She stated the potential risk would be doing CPR on the resident when they had elected to be a DNR. Record review of the facility's Advance Directives policy, revised [DATE], reflected the following: The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance Directives are honored in accordance with state law and facility policy. Determining Existing of Advance Directives: 1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his legal representative, about the existence of nay written advance directives.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on interview and record review, the facility failed to assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every three months for 1 of 5 (Resident #80) residents reviewed for MDS assessments. The facility failed to complete Resident #80's Quarterly MDS Assessment within three months of their most recent comprehensive assessment. This failure could lead to residents not receiving care required for their individualized needs. Findings included: Record review of Resident #80's Admission Record dated 08/29/2024 reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. Review of Resident #80's Significant Change in Status MDS assessment dated [DATE] reflected the resident had moderate cognitive impairment with a BIMS score of 11. Her diagnoses included diabetes (a chronic disease that affects how the body uses insulin and glucose), hypothyroidism (the thyroid gland does not make enough thyroid hormone), and dysphagia (difficulty swallowing that can be caused by various conditions that affect the throat or esophagus). Review of Resident #80's electronic health record reflected there was not a more recent MDS Assessment submitted since 04/25/2024. Interview on 08/28/24 at 2:25 PM the MDS Coordinator revealed she was responsible for completing MDS assessments. The MDS Coordinator said she thought Resident #80 had discharged from the facility and that her MDS was not showing it was due on her end. The MDS Coordinator said a resident's MDS asessment was due every three months from the date of the last completed MDS. The MDS Coordinator said Resident #80's MDS assessment should have been done by 07/25/2024. The MDS Coordinator said the purpose of the MDS assessment was that it told Medicaid and Medicare services what level of care the resident received and kept track of if they had a significant decline or listed what was going on with them in detail. The MDS Coordinator said there was a consultant that normally told her if an assessment was late, or he would bring things to her attention related to MDS assessments. Follow-up interview on 08/28/2024 at 2:39 PM with the MDS Coordinator revealed Resident #80's MDS assessment was on the schedule but was missed. Interview on 08/29/2024 at 3:23 PM, the DON revealed Resident #80's MDS assessment was missed and she was not sure why. The DON said it was a regulation that a resident's MDS assessment was supposed to be done every 92 days. Interview on 08/29/2024 at 4:14 PM, the Administrator revealed the facility did not have a policy that addressed MDS assessments.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights as set forth at 483.10(c) and 483.10(c)3, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for one of eight residents (Resident #239) for care plan revisions, in that: The facility failed to develop a care plan addressing Resident #239's elected code status or advance directive. These failures could place residents at risk of receiving inappropriate care. Findings included: Record review of Resident #239's face sheet dated [DATE] reflected the resident was a [AGE] year-old female admitted on [DATE]. Record review of Resident #239's Admission MDS assessment dated [DATE] reflected the resident's cognition was intact with a BIMS score of 15. The resident's diagnoses included multiple sclerosis (chronic disease of the central nervous system), anxiety disorder (mental health disorder) and hyperkalemia (high potassium). Record review of Resident #239's care plan dated [DATE] reflected there was not a care plan addressing the resident's code status or advance directives. Record review of Resident #239's physician order summary report dated [DATE] reflected it did not have an active physician's order for code status, such as full code status or any other order to support her advanced directive. Record review of the facility's Order List Report dated [DATE] located in the facility's emergency crash cart reflected Resident #239 was not on the list for code status. Interview on [DATE] at 10:24 AM, Resident #239 stated admitted to the facility about two weeks ago. Resident #239 stated she had not been asked about her code status. She stated her preference would be DNR. Interview on [DATE] at 10:35 AM, LVN K stated she was the nurse assigned to Resident #239. LVN K stated when a resident admitted to the facility, it was the responsibility of the admission nurse to ask the resident for their code status and document in the resident's chart. LVN K stated it was the responsibility of the Social Worker to follow-up with the resident and include the code status in the resident's care plan. LVN K reviewed Resident #239 clinical records and stated she was not aware Resident #239 did not have a physician order for code status or that it was not documented in the resident's care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #239's physician order summary report dated [DATE] reflected a physician order for Full Code. Interview on [DATE] at 10:56 AM, the Social Worker stated it was the responsibility of the admission nurse to ask residents about their code status. She stated she would follow-up shortly after their admission. She stated once she obtained the resident's code status it was her responsibility to care plan it. She stated she was not aware Resident #239's code status was not documented in the resident's chart. She stated the code status should be in PCC (electronic health record system) under the physician orders and care plan. She stated Resident #239's code status was Full Code, and she forgot to care plan Resident #239's code status. She stated the risk of not having a code status would be doing CPR or not doing CPR. Interview on [DATE] at 2:46 PM, the ADON stated it was the responsibility of the admission nurse to obtain and document code status. She stated she was not aware Resident #239 did not have a code status until today ([DATE]) when LVN K informed her. She stated it was the responsibility of the social worker to follow up when she completes her code status audits. The ADON stated code status should be care planned which were completed by the social worker. She stated the potential risk of not having code status would be confusion during an emergency. Interview on [DATE] at 3:23 PM, the DON stated advance directives were obtained upon a resident's admission to the facility by the admitting nurse. She stated the Social Worker would then follow-up with the resident. She stated she was not aware Resident #239 did not have a code status. She stated she was informed today ([DATE]). She stated she expected her nurses to obtain residents' code statuses upon admission, and she expected the Social Worker to follow-up and care plan the code status. She stated code status should be documented in PCC and on the care plan. She stated the potential risk would be doing CPR on the resident when they had elected to be a DNR. Record review of the facility's Care Planning - Interdisciplinary Team policy, revised [DATE], reflected: The interdisciplinary team is responsible for the development of resident care plans. Record review of the facility's Advance Directives policy, revised [DATE], reflected: The plan of care for each resident is consistent with his or her documented treatment preferences and/or advance directive.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on interview and record review, the facility failed to ensure a final summary of the resident's status at the time of the discharge was available for release to authorized persons and agencies, with consent of the resident or resident's representative for 1 of 3 residents (Resident #87) reviewed for discharge summary. The facility failed to complete a discharge summary after Resident #87 left the facility and did not return. This failure could place residents at risk for a lack of continued care and services. Findings included: Record review of Resident #87's face sheet dated 08/29/2024 reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. He discharged from the facility on 08/08/2024 to his home. Record review of Resident #87's most recent MDS assessment dated [DATE] reflected he had diagnoses of bipolar disorder (a mental health condition that causes extreme mood swings between emotional highs and lows) and alzheimer's disease (a brain disorder that causes memory loss, thinking problems, and behaviors changes). The MDS assessment did not indicate the BIMS score was captured at the time of completion. Record review of Resident #87's August 2024 Progress Notes reflected there was no documentation concerning the resident's discharge from the facility. Record review of Resident #87's assessments did not reflect any information about his discharge on 08/08/2024. Interview on 08/29/2024 at 11:43 AM, the Social Worker revealed Resident #87 was taken out of the facility on pass with his family, and they never brought the resident back. She said Resident #87 left the faciity on pass often with his family, so there was not a concern when he left and did not return. She said she did not complete a discharge summary for Resident #87 but would normally complete one when a resident discharged from the facility. She said she was responsible for completing the discharge summary, and she was not sure why she did not complete one. She said the purpose of the discharge summary was to find out what the resident needed in the community such as equipment or services. She stated if a discharge summary was not completed, the resident could be at risk for readmission or wind up in the hospital. The Social Worker stated she was not aware that anyone was monitoring to ensure that discharge summaries were completed after a resident discharged . (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/29/2024 at 3:23 PM, the DON revealed the facility did not have a UDA for a resident's discharge summary for staff to fill out. She said she would assume a nurse would at least add a progress note in the resident's chart related to the discharge. She said Resident #87 went out on pass with his family to visit for a few days when the resident's family called and said they did not want him to return to the facility. The DON said Resident #87's discharge was not planned and was determined by the family that he would just stay home with them. She said she thought the Social Worker should have made a note about it in Resident #87's chart since she was the last person to talk to his family. She said the purpose of a discharge summary or note was to have the information to know where people went. She said the concern was that staff might think the resident was missing if they did not see the resident had discharged . The DON said she was not sure if anyone was monitoring to ensure discharge summaries or notes were being completed. Interview on 08/29/2024 at 4:14 PM, the Administrator revealed the facility did not have a policy that addressed discharge summaries.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 41781 Based on interview and record review, the facility failed to use the service of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week for 5 of 30 days (05/25/2024, 05/26/2024, 06/01/2024, 06/08/2024, and 06/15/2024) reviewed during a look back period from 05/25/2024 to 08/25/2024 for weekend coverage. The facility failed to have RN coverage in the facility for eight consecutive hours on 05/25/2024, 05/26/2024, 06/01/2024, 06/08/2024, and 06/15/2024. This failure could place residents at risk for not having their nursing and medical needs met and improper care. Findings included: Review of the facility's Time Detail Reports from 05/25/2024 to 08/25/2024 reflected the following: - RN C worked from 6:00 PM to 10:00 PM (4 total hours), clocked out for lunch, then resumed work from 10:30 PM to 12:00 AM (1.5 total hours) on 05/25/2024. RN E worked from 6:00 PM to 11:00 PM, clocked out for lunch, then resumed work from 11:30 PM to 12:00 AM (.5 total hours) on 05/25/2024. RN D worked from 6:00 PM to 11:00 PM, clocked out for lunch, then resumed work from 11:30 PM to 12:00 AM (.5 total hours) on 05/25/2024. - RN B worked from 12:00 AM to 6:30 AM (6.5 total hours) and 6:00 PM to 11:00 PM (5 total hours), clocked out for lunch, then resumed work from 11:30 PM to 12:00 AM (.5 total hours) on 05/26/2024. RN D worked from 12:00 AM to 6:45 AM (6.75 total hours) and 6:00 PM to 11:00 PM (5 total hours), clocked out for lunch, then resumed work from 11:30 PM to 12:00 AM (.5 total hours) on 05/26/2024. - RN B worked from 6:00 PM to 11:00 PM (5 total hours), clocked out for lunch, then resumed work from 11:30 PM to 12:00 AM (.5 total hours) on 06/01/2024. - RN C worked from 6:00 PM to 11:00 PM (5 total hours), clocked out for lunch, then resumed work from 11:30 PM to 12:00 AM (.5 total hours) on 06/08/2024. RN D worked from 6:00 PM to 11:00 PM (5 total hours), clocked out for lunch, then resumed work from 11:30 PM to 12:00 AM (.5 total hours) on 06/08/2024. - RN C worked from 6:00 PM to 11:00 PM (5 total hours), clocked out for lunch, then resumed work from 11:30 PM to 12:00 AM (.5 total hours) on 06/15/2024. RN B worked from 6:00 PM to 11:00 PM (5 total hours), clocked out for lunch, then resumed work from 11:30 PM to 12:00 AM (.5 total hours) on 06/15/2024. RN F worked from 9:06 AM to 12:27 PM (3.5 total hours) on 06/15/2024. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/29/2024 at 3:23 PM, the DON revealed the RNs usually doubled up on the weekend shifts. The DON said she expected the RN to work 8 consecutive hours on the weekends. The DON said the purpose of this was for coverage reasons so there was always someone in the building to oversee everything. The DON said a lot of things can happen if an RN was not in the building working at least 8 consecutive hours each day. Interview on 08/29/2024 at 4:14 PM, the Administrator revealed the facility did not have a policy that addressed RN coverage.

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NAME OF PROVIDER OR SUPPLIER Birchwood of Grapevine		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Autumn Drive Grapevine, TX 76051	

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42859 Based on observation, interview and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 (medication cabinet in the central supplies unit) and one refrigerator in the medication room for 100 and 200 halls reviewed for pharmacy services. The facility failed to ensure expired influenza vaccine, with an expiration date of 05/10/2024, in the Hall 100/200 Medication Room refrigerator and expired medications in the Central Supply medication cabinet were removed and destroyed on 08/28/2024 at 10:45 AM. The failure placed residents at risk of receiving medications that were ineffective due to having expired. Findings included: Observation on 08/29/2024 at 10:45 AM of the 100 and 200 Medication Room refrigerators with LVN K revealed 4 vials of the influenza vaccine lot 370677 with expiration date of 05/10/2024. Interview on 08/29/2024 at 10:55 AM, LVN K stated the night shift nurses were the ones who were supposed to check the carts and the refrigerators for expired medications, but it was all nurses' responsibility to check and remove expired medications from the refrigerator. She stated she had done training on when to discard the vaccines once they expired. She stated by failing to remove the expired medication they could be administered and cause reactions, and the resident would not get the required therapy. Interview on 08/29/2024 at 11:05 AM, the ADON stated it was her responsibility to go behind the nurses to check whether they were removing the expired medications from the refrigerators and carts. She stated she could not remember the date she checked the carts and refrigerator, but it was in August. She stated by failing to check for the expired medications, they could be administered and would not be effective. The ADON stated she was not aware whether the facility had offered training to staff regarding removing expired medications. Interview on 08/29/2024 at 11:15 AM, the DON stated she expected the night shift nurses to check the refrigerator for expired medications, and she and the ADON were responsible for following up. The DON stated she checked the carts and the refrigerator in August, but she could not recall the date. She stated if staff were not checking the refrigerator for expired medications and medications were administered to residents, they would not be effective. She stated she had not done training on refrigerator monitoring with staff since she was new to the facility. Observation on 08/29/2024 at 11:20 AM of the facility's Central Supply cabinet where over-the-counter medications were stored revealed the following expired medications: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Saline Nasal spray with expiry date of 08/22/2024, - one bottle of Vitamin B12 with expiry date of April 2024, - one bottle of Vitamin B6 with expiry date of 04/24/2024, and - one bottle of Acetaminophen 500 mg/15 ml with an expiry date of 03/24/2024. Interview on 08/29/2024 at 11:30 AM, the Central Supply Staff stated it was her responsibility to check and ensure medications were labeled and not expired. She stated the cabinet was shared by all the nurses, and she was responsible for acquiring all the over-the-counter medications and storage and ensuring they were not expired. She stated the side effects of giving expired medication was they would not work and would not be effective. She stated all expired medications were supposed to be removed from the cabinet and put in destruction boxes for the Pharmacist to destroy. She stated she had done training on storage and labeling of medications. She stated she had last checked the cabinet on 08/28/2024, and she did not know how she missed the expired medication but stated she thought the nurses removed the medications from their carts and brought them to the cabinet. Interview via telephone was attempted with the night shift nurses on 08/29/2024 at 3:24 PM, but the attempt was not successful and a voice mail was left. Interview on 08/29/2024 at 3:48 PM, the DON stated she expected all over-the-counter medications be labeled and not expired. She stated she and the ADON were responsible for checking the cabinet in the Central Supply Room for expired medications. She stated she checked the cabinet in the Central Supply Room on 08/26/2024, and there were no expired medications. She stated if expired medications were administered to residents, they would not be effective. She stated she had done training on checking for expired medications in the medication carts, refrigerator and the supply unit, but no in-service record was provided prior to exit. Review of the facility's Storage of Medication policy, revised August 2020, reflected the following: .1. Expiration dates (beyond-use dates) of dispensed medications shall be determined by the pharmacist at the time of dispensing. 2. Drugs dispensed in the manufacturers' original container will be labeled with the manufacturer's expiration date. .8. All expired medications will be removed from the active supply and destroyed in accordance with facility policy, regardless of amount remaining.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety for 1 of 1 kitchen and 1 of 1 steamtable reviewed for kitchen sanitation, in that: Cook A placed food containers, of the lunch meal in a steamtable that contained contaminated tinted water and burnt food particles floating in it on 08/28/2024. This failure could place residents at risk for food contamination and foodborne illness. Findings included: Observation on 08/28/2024 at 10:58 AM of the kitchen's steamtable revealed six compartments total, but the first and sixth from the left were not being used and had no water in them. [NAME] A placed hamburger steaks and gravy in the second compartment from the left side that had a few inches of dark brown tinted water in it as well as burnt food particles floating in it. [NAME] A placed pinto beans, pureed pinto beans, and pureed cabbage in the third compartment from the left side that also had a few inches of dark brown tinted water in it. [NAME] A placed cooked cabbage in the fourth compartment from the left that had lots of food particles in it and the water was a yellow or brown tinted color. [NAME] A placed shredded pork loin and mechanical soft pork loin in the fifth compartment from the left side that had lots of food particles in it with yellow tinted water and a salt packet floating in the water. Interview on 08/28/2024 at 1:49 PM, [NAME] A revealed she noticed the steamtable compartments in the kitchen had dirty water in them while she was placing the cooked food for the lunch service earlier. [NAME] A said the night cook was responsible for cleaning the steamtables each night. [NAME] A said she was rushing to get lunch served today but knew not to place cooked food in the steamtable compartments if they were dirty. Interview on 08/28/24 at 1:57 PM, the Dietary Manager revealed she forgot to clean the steamtables last night because she was dealing with something else in the kitchen. She said she told [NAME] A to clean them yesterday and that did not happen. She said the steamtable compartments were supposed to be cleaned after each meal and all kitchen staff knew that. She said she normally checked before meal service to ensure the compartments were cleaned. The Dietary Manager said the purpose of having clean steamtable compartments was because staff should not put clean items on dirty surfaces. She said cross contamination can happen if food was placed in dirty steamtable compartments because the dirty water could get into the food. She said that could make a resident sick. Review of the Federal Food Code 2022 reflected: 4-602.11 Equipment Food-Contact Surfaces and Utensils . 3) Containers in serving situations such as salad bars, [NAME], and cafeteria lines hold READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is maintained at the temperatures specified under Chapter 3, are intermittently combined with additional supplies of the same FOOD that is at the required temperature, and the containers are cleaned at least every 24 hours. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/29/2024 at 4:14 PM, the Administrator revealed the facility did not have a policy that addressed kitchen sanitation.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to establish and 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 diseases and infections for 1 (Residents #2) of 2 residents reviewed for infection control. LVN L failed to put on a gown before entering Resident #2's room to administer a bolus feeding and medications to Resident #2, who was on enhanced barrier precautions. This failure placed residents at risk of cross contamination and the spread of infection. Findings included: Record review of Resident #2's face sheet dated 08/29/2024 reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #2's Quarterly MDS assessment dated [DATE] reflected his diagnoses included hypertension (high blood pressure), dysphagia (difficulty swallowing) and gastrostomy status (presence of an artificial opening in the stomach, also known as a gastrostomy tube). Resident #2 had severe cognitive impairment with a BIMS score of 3. The MDS reflected the resident received his nutrition via feeding tube. Record review of Resident #2's care plan revised on 04/02/2024 reflected: Focus: [Resident #2 is on enhanced barrier precautions. Goal: [Resident #2] will have no complications related to enhance barrier precautions. Interventions: All staff will wear gown and gloves during high-contact care activities. Record review of Resident #2's physician order dated 04/18/2024 reflected: Enteral Feed every 6 hours Nurten 2.0 bolus 1 carton/brick (250 ml) Fluid flush 150 ml before and after each bolus. Observation on 08/28/2024 at 11:53 AM revealed a sign on Resident #2's door reflecting: Stop, enhanced barrier precautions - providers and staff must also wear Gown and Gloves. PPE was outside the room. LVN L entered Resident #2's room to administer Resident #2 a bolus feeding. LVN L performed hand hygiene and then donned gloves. Without donning a gown, LVN L administered a bolus feeding to Resident #2 via the resident's gastrostomy tube. Observation on 08/28/2024 at 2:16 PM revealed a sign on Resident #2's door reflecting: Stop, enhanced barrier precautions - providers and staff must also wear Gown and Gloves. PPE was outside the room. LVN L entered Resident #2's room to administer medications and a bolus feeding to the resident. LVN L performed appropriate hand hygiene and donned a pair of gloves. Without donning a gown, LVN L administered medications via gastrostomy tube to Resident #2. (continued on next page)

Printed: 12/04/2024
Form Approved OMB
No. 0938-0391

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/28/2024 at 2:37 PM, LVN L stated she was the nurse assigned to Resident #2. LVN L stated she saw the PPE at the door, and she was aware they were for enhanced barrier. She stated the PPE was supposed to be worn during care, at all times, but she forgot. She stated any resident who had a catheter, g-tube, or wound was on enhanced barrier precautions. She stated Resident #2 was on enhanced barrier precautions due to having a g-tube. She stated she should have donned a gown but forgot to do it. She stated the risk of not donning PPE was that it could lead to the spread of infection. She stated she could not remember whether she had done training on enhanced barrier precautions. Interview on 08/28/2024 at 2:55 PM, the DON stated she expected staff to put on PPE when providing care to a resident who had a wound, catheter, or a g-tube. She stated residents who were on enhanced barrier precautions had signs on their doors to indicate the resident was on enhanced barrier precautions. The DON stated Resident #2 was on enhanced barrier precautions due to having a g-tube and staff should put on PPE before providing any type of care. She stated the potential risk of not putting on PPE would be spread of infection. She stated the facility had done training on infection control and enhanced barrier precautions. Record review of the facility's training records reflected training on infection control, reverse isolation and enhanced barrier precaution dated 04/15/2024 and 04/2/2024. The records reflected LVN L was not in attendance. Record review of the facility's Enhanced Barrier Precautions policy, dated August 2024, reflected: 1. Enhanced barrier precautions (EBP) are used an infection prevention and control intervention to reduce the spread of multi-drug resistant organism to residents. .3. Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include: a. Dressing b. Bathing /showering c. Providing hygiene .g. Device care use (central line urinary catheter, feeding tube and h. Wound care (any skin opening requiring a dressing) .