STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675967	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northgate Plaza	2101 Northgate Dr Irving, TX 75062

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054 Based on interview and record review, the facility failed to ensure the residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #1) of 6 residents reviewed for quality of care. -The facility failed to follow the Infectious Disease NP recommendation given on [DATE] to transfer Resident #1 to the hospital after the resident exhibited s/sx of an infection that included increased confusion, lethargy, hypotension (low blood pressure), and lab work that was positive for leukocytosis (elevated white blood cells). Resident #1 continued to be symptomatic and was not sent out to the hospital until [DATE] where he was diagnosed with acute metabolic encephalopathy (impaired brain function) due to sepsis (infection in bloodstream), UTI (infection of urinary system), aspiration pneumonia (lung infection) and infected decubitus ulcer (pressure ulcer). Resident #1 expired at a local hospital on [DATE]. An Immediate Jeopardy (IJ) was identified on [DATE] at 03:56 PM and an IJ Template was provided to the Operations Manager at 05:38 PM. While the Operations Manager and Clinical Resource were notified that the IJ was removed on [DATE] at 3:36 PM, the facility remained out of compliance at a scope of isolated with the severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place all residents requiring assistance with incontinence care at risk for urinary tract infections that could lead to serious harm or death. Findings included : Record review of Resident #1's face sheet, dated [DATE], reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included: type II diabetes (body's inability to control blood glucose), hypotension (low blood pressure), dementia (loss of memory and thinking abilities), pressure ulcers, hx of urinary tract infection, hx of bacterial infection, hx of fracture of vertebrae (back fracture), and acute kidney failure. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Nursing Home PPS MDS Assessment, dated [DATE], reflected Resident #1 had a BIMS score of 5, which indicated severe cognitive impairment. This document also reflected, under Section GG - Functional Abilities, Resident #1 was totally dependent on staff for toileting hygiene. Further review of the document reflected, under Section H-Bladder and Bowel, Resident #1 always had urinary incontinence. Record review of Resident #1's Care Plan, revised on [DATE], reflected the resident had a hx of UTIs and was on PO ABX prophylactically (as a preventative measure) indefinitely. Interventions included: Check for incontinence. Wash, rinse and dry soiled areas. Encourage adequate fluid intake. Give antibiotic therapy as ordered. Monitor and document for side effect and effectiveness. The care plan also reflected Resident #1 had bowel/bladder incontinence r/t confusion and impaired mobility. Interventions included: Incontinent: Check as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN after incontinence episodes. Monitor, document for s/sx of UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, fouls smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Further review of this document reflected Resident #1 had the potential for pressure ulcer development r/t impaired mobility and incontinence. Interventions included: Monitor nutritional status. Serve diet as ordered, monitor intake and record. Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration noted during bath or daily care. Use lifting device, draw sheet, etc. to reduce friction. Weekly head to toe skin at risk assessment. Record review of Resident #1's progress notes, dated [DATE] at 9:00 AM by the FNP, reflected the following: . Increased confusion ***History of Present Illness*** [Resident #1], [AGE] year-old male long-term care resident of the facility, is being seen today for an acute visit due to increased confusion, as reported by nursing staff. The [Resident #1's], family noted that he appeared increasingly confused over the weekend. [Resident #1] is currently on prophylactic Macrobid due to recurrent UTIs. On examination today, the [Resident #1] is sitting upright in a wheelchair in his room, in no acute distress. [Resident #1] reports he is doing well and appears at baseline mentation; however, he appears more tired than his baseline. Given the change in symptoms and family's concerns, CBC, BMP, and UA will be obtained to rule out acute infection. The patient denies any current UTI symptoms and any other clinical concerns today. Previously, [Resident #1] was hospitalized from [DATE] to [DATE], due to altered mental status secondary to UTI. He returned to the facility at baseline mentation. On [DATE], during his ER follow-up visit for UTI, he was noted to be at baseline mentation and able to recall his recent hospital stay. Prior to this, on [DATE], he was seen for UTI and was treated with cefdinir Record review of Resident #1's progress notes, dated [DATE] at 10:00 AM by the FNP, reflected the following: (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	leukocytosis (elevated white blood cells) and suspected UT [sic] ***History of Present Illness*** [Resident #1], an [AGE] year-old male long-term 'care resident of the facility with a history of dementia and recurrent UTIs, is being seen today for an acute visit due to leukocytosis and suspected UTI. CBC and BMP this morning revealed leukocytosis, with a white blood cell count of 11.6 per nursing. Nursing is continuing to attempt to obtain a UA; a straight cath was attempted but was unable to obtain urine. The [Resident #1] reports they will try again today. Nursing also reports the [Resident #1] was noted with increased confusion yesterday and asked where he was, which is not his baseline mentation. On examination, the patient was seen in the dining hall in no acute distress. He reports he is doing well and denies any UTI symptoms or any clinical concerns today. Previously, on [DATE], the [Resident #1] was seen for increased confusion, and labs were ordered to rule out acute causes of altered mental status. On [DATE], he was seen for possible shingles, and acyclovir (antiviral) and prednisone (steroid) were initiated for unilateral (one-sided) red blisters on the right mid back. On [DATE], [Resident #1] was seen for an ER follow-up for a UTI, during which he was noted to be at his baseline mentation and able to recall his recent hospital stay after being admitted for acute encephalopathy secondary to UTI. . ***Lab Results*** ,d+[DATE]: -- MAC (bacterium) Yes ,d+[DATE]: --- [NAME] (type of WBC) >100,000 ,d+[DATE]: CBC pending ,d+[DATE]: --- WBC 11.6 ; Range: 3XXX,d+[DATE].2 ,d+[DATE]: --- CBC pending ,d+[DATE]: UA pending ,d+[DATE]:-- UA pending ,d+[DATE]: BMP pending ,d+[DATE]: --- BMP pending * N39.0 - URINARY TRACT INFECTION, SITE NOT SPECIFIED *: The [Resident #1] presents today with leukocytosis (WBC 11.6) and suspected UTI. Nursing is continuing to attempt to obtain UA. Straight cath was attempted; however, unable to obtain urine. Will initiate cefdinir (abx)300 mg twice daily x 7 days with orders to initiate antibiotic after obtaining UA. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	* D72.829 - Elevated white blood cell count, unspecified *: CBC this morning revealed elevated WBC count of 11.6. Will monitor and trend with follow up labs. * R41.0 - Disorientation, unspecified *: The [Resident #1] was noted with increased confusion yesterday and asked where he was, which is not his baseline mentation. Given the change in symptoms, further evaluation is warranted to rule out acute causes of altered mental status Record review of Resident #1's lab result report, dated [DATE], reflected in part the following: Collection Date: [DATE] Received Date: [DATE] Reported Date: [DATE] Basic Metabolic Panel: Glucose-Results: 117; Range ,d+[DATE] . CBC: WBC-Results: 11.6, Range: 3XXX,d+[DATE].2 RBC-Results: 3.3; Range 3XXX,d+[DATE].5 . Record review of Resident #1's MAR, dated ,d+[DATE], reflected in part the following: -Cefdinir (abx) 300 mg; give 1 capsule by mouth two times a day for UTI for 7 days, may initiate antibiotic after obtaining UA. Order Date: [DATE] Medication administered: [DATE] (am/pm), [DATE] (am/pm), and [DATE] (am) Discontinue Date: [DATE] Record review of Resident #1's progress notes, dated [DATE] at 2:42 PM by the Infectious Disease NP, reflected the following: . ASSESSMENT AND PLAN; 1; [Resident #1] with acute cystitis (UTI). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Urinalysis has been collected, results are pending. Slight leukocytosis. Treated with Cefdinir 300 mg q.12 hours x 7 days. We will watch for antibiotic-related side effects including C. diff (bacteria in colon) and nephrotoxicity (toxicity in the kidneys). We will follow clinical course and culture results. 2; [Resident #1] has diabetes with secondary complications. Further treatment per attending physician. 3; History of generalized muscle weakness. [Resident #1] is wheelchair bound. HPI: [Resident #1] is an [AGE] year-old gentleman, who has a history of multiple medical problems seen for evaluation. [Resident #1] was sitting in a wheelchair not able to give any reliable history. Past medical history as mentioned above. [Resident #1] is seen status post hospital stay due to altered mental status and lethargy. [Resident #1] was seen at [local hospital] and found to have 3rd degree heart block. [Resident #1] underwent a permanent pacemaker placement. [Resident #1] also found to have some pneumonia. [Resident #1] was discharged back to facility on po Levaquin (abx). . Record review of Resident #1's lab result report, dated [DATE], reflected in part the following: Collection Date: [DATE] Received Date: [DATE] Reported Date: [DATE] Urinalysis: Protein -Result: 30 (kidneys were not filtering blood properly); Range: Negative (flagged) Urine Culture: Organism: pseudomonas (bacteria that causes infection) . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's progress notes, dated [DATE] at 4:52 PM by the Infectious Disease NP, reflected the following: ASSESSMENT AND PLAN; 1; [Resident #1] with leukocytosis. Urinalysis on ,d+[DATE] unremarkable (no signs of infection). [Resident #1] was treated with Cefdinir 300 mg q.12 hours x 7 days however staff reported [Resident #1] had increased heart rate and hypotension. Recommendation for [Resident #1] to be seen in emergency department was made however [Resident #1] was not sent. Started IV Zosyn (abx) 3.375 g q.8 hours x 5 days. Stat CBC, BMP and chest x-ray ordered. We will follow clinical course and watch for antibiotic-related side effects including C. diff and nephrotoxicity. 2; [Resident #1] has diabetes with secondary complications. Further treatment per attending physician. 3; History of generalized muscle weakness. [Resident #1] is wheelchair bound . Record review of Resident #1's lab result report, dated [DATE], reflected in part the following: Collection Date: [DATE] Received Date: [DATE] Reported Date: [DATE] Basic Metabolic Panel: Glucose-Results: 117; Range ,d+[DATE] . CBC: WBC-Results: 8.9, Range: 3XXX,d+[DATE].2 RBC-Results: 3.1; Range 3XXX,d+[DATE].5 . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review of Resident #1's progress notes, [DATE]-[DATE], reflected there was not a note documenting why the resident was not sent out to the hospital as recommended by the Infectious Disease NP, or the conversation had between the former DON and the MD. Record review of Resident #1's progress notes, dated [DATE] at 5:46 PM by RN C, reflected the following: [Resident #1] vital signs were monitored, there were no signs of distress noted. Resting in bed. Record review of Resident #1's progress notes, dated [DATE] at 1:35 PM by RN B, reflected the following: [Resident #1] is alert and oriented *2 [sic] (awake and aware of identity and location but may not be aware of the time or current situation), slight confusion noted. [Resident #1] vital signs monitored and was BP , d+[DATE] pulse 85b/min spo2 of 95 % in o2 21/min and RR 17 b/min and temp 98.7 [degrees] f. Stat CBC, CMP and chest Xray report was reviewed and notified [Infectious Disease NP] and MD about report. Resident antibiotic cefdinir and IV Zosyn (abx) was discontinued by [Infectious Disease NP], which was started because of leukocytosis and [Resident #1] WBC came normal. [Resident #1] kept on semi-Fowlers (medical posture where a patient lies on their back with their head and upper body raised ,d+[DATE] degrees) position to ease breathing. [Resident #1] was encouraged for fluid intake and timely fluid was given. [Resident #1] kept under close monitor for any change in his behavior and his condition. Ongoing plan of care. Will continue to monitor. Record review of Resident #1's progress notes, dated [DATE] at 5:40 PM by RN A, reflected the following: [Resident #1] was alert and oriented. spo2 was 95% maintained in o2 @ 2 l/m via nasal cannula. [Resident #1] was in semi-Fowlers position. [Resident #1] has no discomfort and pain. [Resident #1] safety was maintained. discontinue CEFDIFIR AND iv ANTIBIOTICS as normal WBC in recent report. Record review of Resident #1's progress notes, dated [DATE] at 5:58 AM by RN B, reflected the following: [Resident #1] is confused and drowsy confusion. [Resident #1] vital signs monitored and was BP ,d+[DATE] pulse 75b/min spo2 of 97 % in o2 2 l/min and RR 20 b/min and temp 98. 7 [degrees] f. [Resident #1] kept on semi-Fowlers position to ease breathing. [Resident #1] was encouraged for fluid intake and timely fluid was given. Resident kept under close monitor for any change in his behavior and his condition. Ongoing plan of care. Will continue to monitor. Record review of Resident #1's progress notes, dated [DATE] at 9:18 AM by RN A, reflected the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	[Resident #1] is confused and drowsy. [Resident #1] was not responded [sic] to verbal command properly. [Resident #1] vital signs monitored and was BP ,d+[DATE] pulse 73b/min spo2 of 95 % in o2 2 l/min and RR 20 b/min and temp 98.7 f. [Resident #1] kept on semi-Fowlers position to ease breathing. resident seems dehydrated and lethargic. [Resident #1] was encouraged for fluid intake, but he was not responding. [Resident #1] has changed in his behavior from last night. inform to [former DON] and [MD]. [Resident #1] [family] was witness for all [Resident #1] condition. [Resident #1] transported to [local hospital] at 7:35 am. Record review of Resident #1's hospital records, dated [DATE], reflected in part the following: [AGE] year-old male with past medical hx of dementia, chronic a fibrillation, type II diabetes, hypertension, pacemaker for third degree block, HLD, CVA, long term resident at [Nursing Facility] was sent to ER for altered mental status. [Resident #1] poor historian and dementia, unable to obtain HPI. [Resident #1] [family] was at bedside and reported that for past one week he has been getting weaker and getting more lethargic. [Family] reported to nursing staff the change in his status. Today [Resident #1] was not responding to nursing staff and found to have low blood pressure with fever so was sent via EMS. . Significant Findings/Diagnostic Studies: -admitted for acute metabolic encephalopathy due to sepsis -Workup showed UTI aspiration pneumonia and infected decubitus ulcer . -Urine culture growing Pseudomonas -Blood culture Bacteroides (nitrogen-fixing bacterium) -Tissue culture showed multiple organisms -Received IV antibiotics -Palliative care evaluated [Resident #1] because of advanced dementia and poor prognosis. [Family] wanted hospice . Further review of this document reflected it did not indicate which infection, the UTI or infected decubitus ulcer, caused Resident #1 to become septic. Record review of Resident #1's order summary report, dated [DATE], reflected in part the following: -Lactobacillus rhamnosus (probiotic used for gut health) oral capsule; Give 1 capsule by mouth one time a day for restore normal flora Order Date: [DATE] (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	End Date: [DATE] -Macrobid oral capsule 100 MG; Give 1 capsule by mouth one time a day for UTI prophylaxis Order Date: [DATE] End Date: [DATE] -Cefdinir Capsule 300 MG: Give 1 capsule by mouth two times a day for UTI for 7 days Order Date: [DATE] End Date: [DATE] In an interview on [DATE] at 9:25 AM, Resident #1's family stated the resident resided at the nursing facility for about 4 years and there were concerns with the care throughout the stay; however, the resident wanted to remain there. The family stated different family members visited Resident #1 almost daily and were active in his care planning. The family stated she visited Resident #1 on [DATE] and found that the resident was not acting like himself, so she asked the former DON to complete a urine test. The family stated after 2 days, the urine test still had not been completed and the former DON stated he forgot to order it. The family stated the urine sample was finally taken on [DATE]. She stated the wound care MD contacted her on [DATE] and informed that Resident #1 had been placed on a broadband antibiotic and fluids for symptoms of a UTI. The family stated on the morning of [DATE], the family could see on the video monitor in Resident #1's room that something was wrong with him, so they went up to the nursing facility. The family stated Resident #1 was unarousable and they demanded that 911 be called. She stated Resident #1 was transported to the local hospital and was diagnosed with severe sepsis from a UTI and wound infection . The family stated the infection was too severe and hospice was the only option. The family stated they agreed to transfer Resident #1 to a hospice center, and he expired on [DATE]. In an interview on [DATE] at 1:29 PM, RN A stated she worked at the facility for 2 months. She stated she worked with Resident #1 on [DATE] when he was sent out to the hospital. RN A stated when she came on shift at 6:00 AM, she received report from RN B that Resident #1 had not acted like himself during the evening and night shift. RN A stated it was reported that the resident slept a lot and was not expressing himself like usual. RN A stated during her rounds, she noticed he had a change in condition. She stated Resident #1 was alert but would not respond verbally and was very low energy. RN A stated Resident #1's family came to the facility around 7:00 AM and agreed that something was wrong. RN A stated she called 911, then notified the former DON and MD. She stated Resident #1 was transported to the hospital by EMS. RN A stated she worked with Resident #1 over the past few days, and he showed gradual changes. She stated he seemed less aroused each day, but he was seeing the MD throughout the week and was on antibiotics, so she was not alarmed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 11:32 AM, the Infectious Disease NP stated he visited Resident #1 on , d+[DATE] and reviewed lab work ordered by the FNP. He stated the lab work showed Resident #1's WBC was elevated, and he was positive for leukocytosis. The Infectious Disease NP stated Resident #1 had already been started on PO abx. He stated the nurse reported that day that Resident #1's blood pressure was low, and he was continuing to show s/sx of an infection. The Infectious Disease NP stated he recommended that Resident #1 be sent to the hospital based on his hx of infections and sepsis. The Infectious Disease NP stated he ordered another set of labs and IV abx in the meantime on [DATE]. The Infectious Disease NP stated he was not informed whether Resident #1 was sent to the hospital as recommended on [DATE]. He stated when he gave a recommendation, it was up to the facility to follow it or consult with the MD. He stated the expectation was for the facility to notify him if they decided against his recommendation. The Infectious Disease NP also stated he was not informed whether the IV abx were started. He stated the labs he ordered resulted on [DATE] and the results showed Resident #1's WBC was within normal range, the leukocytosis resolved, and the UA was unremarkable, so he discontinued the PO abx order by the FNP and the IV abx ordered by him. He stated Resident #1 also did not have a fever and his chest X-ray was negative for pneumonia. The Infectious Disease NP stated when he returned to the facility on [DATE], he found that Resident #1 had been discharged to the hospital. In an interview on [DATE] at 12:17 PM, RN B stated she worked at the facility for about 6 months. She stated she worked with Resident #1 during the evening on [DATE]. She stated an order for IV abx was put in by the Infectious Disease NP earlier that day, but he discontinued it along with the PO abx later that day. She stated she was about to contact the provider to come insert the PICC line just as the order was discontinued, so the IV abx was never started. RN B stated the previous nurse gave report that Resident #1 had been drowsy and was not as responsive as usual. RN B stated Resident #1 had been that way for a few days and had seen the FNP. In an interview on [DATE] at 3:04 PM, the MD stated the facility attempted to notify him of Resident #1's change of condition and initially could not reach him; however, he called back and spoke with the former DON. The MD stated he recalled having a conversation with the former DON about Resident #1 being sent out to the hospital as recommended by the Infectious Disease NP, and he did not object to it. The MD stated from what he understood regarding the symptoms Resident #1 was exhibiting, based on his history of infections and the hemodynamics (study of blood flow), the resident appearing unstable he could not think of a rationale against sending him out. The MD stated the former DON would not have had the authority to decide to not send Resident #1 out himself. The MD stated it was reasonable to get Resident #1 assessed at the hospital, so he was not placed at an increased risk of getting sepsis due to his hx. In an interview on [DATE] at 2:45 PM, the Operations Manager stated the former DON was not terminated for any reasons directly related to Resident #1 because management was unaware of the issue prior to the investigation; however, it was for poor job performance and lack of follow up on tasks and concerns, which was similar to the incident of miscommunicating information from the MD regarding Resident #1. Attempted interview on [DATE] at 4:06 PM with LVN L was unsuccessful due to no response to call. Attempted interview on [DATE] at 11:21 AM with LVN L was unsuccessful due to no response to call. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northgate Plaza	2101 Northgate Dr Irving, TX 75062

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's policy titled Nursing Administration-Incontinence, Urinary, revised ,d+[DATE], reflected in part the following: Policy: It is the policy of this facility that: . 2. A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Purpose: 1. Each resident who is incontinent of urine is identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible. PROCEDURES: Assessment: 1. Resident will be evaluated at admission, quarterly and whenever there is a change in cognition, physical ability, or urinary tract function. This evaluation is to include identification of individuals with reversible and irreversible (bladder tumors and spinal cord disease) causes of incontinence. . Interventions: 1. Provide Incontinent Care. . 4. Treat underlying conditions that have a potentially negative impact on the degree of continence (delirium causing urinary incontinence related to acute confusion). . The Operations Manager, Clinical Resource, and DON were notified of an Immediate Jeopardy (IJ) on [DATE] at 5:38 PM, due to the above failures and the IJ Template was provided at 05:38 PM. The facility's Plan of Removal (POR) was accepted on [DATE] at 8:34 AM and included: [Nursing Facility] Plan of Removal . [DATE] Version 1 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Per the information provided in the IJ Template given on [DATE], the facility failed to follow the Nurse Practitioner's recommendation to send Resident #1 to the hospital for symptoms of an infection. Immediate Action 1. The Medical Director was notified of IJ on [DATE] at 5:52pm by the Clinical Resource RN. 2. Resident #1 was transferred to the hospital on [DATE] and did not return to the facility. 3. The DON, Clinical Resource RN, and Cluster Partner RN initiated an audit on [DATE] that will be completed on [DATE] on all residents currently being treated for a UTI to ensure orders are in place and care plans updated. 4. Training and knowledge checks for changes in condition, UTI, and sepsis will be completed with all nursing staff. This training will be initiated on [DATE] and will be completed by [DATE]. This training will be provided by the Director of Nursing, Cluster Partner DONs/RNs, and Clinical Resource RNs. 5. This training will be completed with all nursing staff prior to the start of their next shift. Staff will not be allowed to work unless they have completed the training and knowledge checks. This training will also be included in the new hire orientation and will be included for agency /PRN staff prior to starting work on the floor. These staff will not be allowed to work unless they have received their training and knowledge check. 6. An ad hoc meeting regarding items in the IJ template will be completed on [DATE]. Attendees will include the Medical Director, DON, Clinical Resource RN, Administrator, Operations Manager, and Cluster Partner DON/RN and will include the plan of removal items and interventions. 7. Daily monitoring will be completed by the DON to include review of the 24-hour report for signs and symptoms of UTI, sepsis, and change of condition. 8. The Directors of Nursing or Clinical Resource RN will verify staff knowledge checks on change of condition, signs and symptoms of a UTI and sepsis with 10 nursing staff weekly. 9. All changes of condition will be reviewed at the weekly clinical meeting. The Medical Director will be notified for recommendations as necessary. Attendees at this meeting will include DON, wound nurse, Clinical Resource RN, Director of Rehab, MDS nurse. This process will begin [DATE] and will be ongoing. 10. Summary of IJ and corrective action to be reviewed by QAPI Committee weekly x 4 weeks or until substantial compliance established and continue monthly for 90 days to ensure ongoing compliance. On [DATE] the investigator began monitoring (9:45 AM-02:45 PM) to determine if the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy by: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observations, interviews , and record reviews on [DATE] from 10:00 AM-11:15 AM of Residents #1, #2, #5, #6, #7, and #8 revealed no further concerns for incontinence care or infections. Record review of residents' EHRs reflected no concerns for changes in physical, mental, or psychosocial status. Observations and interviews with residents and/or RPs revealed no concerns for change of condition or quality of care received. Record review of a document provided by the Clinical Resource titled Order Listing Report, dated [DATE]-[DATE], reflected all residents with active UTIs received a chart audit to ensure that orders were in place and care plans were updated. Record review of a document provided by the Clinical Resource titled 24 Hour Summary, dated [DATE]-[DATE], reflected all residents received a clinical assessment for s/sx of

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054 Based on observation, interview, and record review the facility failed to ensure each resident received food that accommodates resident allergies, intolerances, and preferences for 2 residents (Resident #3 and Resident #4) of six residents reviewed for food preferences. -The facility failed to ensure Resident #3 and Resident #4 had nutritious and palatable meal substitutes to meet their intolerances and/or preferences. This failure could place residents at risk of not having their daily nutritional needs met, placing them at risk for weight loss and a diminished quality of life. Findings included : Record review of Resident #3's face sheet, dated 3/26/25, reflected the resident was a [AGE] year-old male who originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: hemiplegia and hemiparesis affecting left non-dominant side (muscle weakness and partial paralysis), depression (mood disorder), epilepsy (seizure disorder), protein-calorie malnutrition, and GERD. Further review of the document reflected Resident #3 was on a mechanical soft texture, and thin liquids consistency diet. Record review of Resident #3's Quarterly MDS Assessment, dated 2/5/25, reflected Resident #3's BIMS score (used to assess a resident's cognitive function) was not documented. Further record review of the document reflected, under Section K - Swallowing/Nutritional Status, Resident #3 did not have a swallowing disorder and was not on a therapeutic diet. Record review of Resident #3's Care Plan, undated, reflected the resident had GERD. Interventions included: Give medications as ordered. Monitor vital signs as ordered. Monitor, document, report to MD PRN s/sx of GERD. Obtain and monitor lab/diagnostic work as ordered. Further review reflected Resident #3 had a nutritional problem related to dysphasia (difficulty swallowing). Interventions included: Diet as ordered by the physician. G-tube-cleanse stoma (surgically created opening in the abdomen that allows waste to exit the body) with NS, pat dry, and leave open to air. Meals in dining room if resident is in agreement. Monitor and report to MD as needed for any s/sx of decreased appetite, n/v, unexpected weight loss, c/o stomach pains. Provide, serve diet as ordered. Monitor intake and record every meal. RD to evaluate and make diet changes recommendations PRN. Supplements as directed by physician. Record review of Resident #4's face sheet, dated 3/26/25, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included: bipolar disorder (mood disorder), morbid obesity, hypertension (high blood pressure), acute kidney failure, and heart failure. Further review of the document reflected Resident #4 was on an RCS NAS diet, regular texture, and thin liquids consistency. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's Annual MDS Assessment, dated 12/28/24, reflected Resident #4's BIMS score (used to assess a resident's cognitive function) was not documented. Further record review of the document reflected, under Section K - Swallowing/Nutritional Status, Resident #4 did not have a swallowing disorder; however, she was on a therapeutic diet. Record review of Resident #4's Care Plan, undated, reflected the resident had GERD. Interventions included: Avoid lying down for at least 1 hour after eating. Keep HOB elevated. Encourage to stand/sit upright after meals. Avoid overeating. Avoid snacks that aggravate the condition. Dietary: avoid foods or beverages that tend to irritate esophageal lining. Give medications as ordered. Monitor vital signs as ordered. Monitor, document, report to MD PRN s/sx of GERD. This document also reflected that Resident #4 had a nutritional problem AEB morbid obesity and was at risk of malnutrition r/t lack of appetite. Further review reflected the resident preferred not to eat breakfast and requested no pork and no gravy on her foods, with additional vegetable. Interventions included: Breakfast tray will be provided, and CNA will document refusal. Diet as ordered by the physician. Honor resident rights to make personal dietary choices and provide dietary education as needed. Monitor, record, report to MD PRN s/sx of malnutrition. Supplements as ordered by provider. In an interview on 3/26/5 at 10:18 AM, Resident #4 stated she was on a special diet due to having GERD and kidney disease. She stated her main concern was that the facility's kitchen did not always serve meals that she could eat and because of that she had to purchase her own food, mostly salads, and keep it in her personal refrigerator in the room. Resident #4 stated the staff never offered her a substitute and would just deliver whatever was being served. Resident #4 stated the kitchen would accommodate her special diet by not adding salt; however, they would still serve her foods like pasta. She stated tomato sauce upset her stomach, but they would still serve her meatloaf and spaghetti, and on those days, she would just eat one of her salads. Resident #4 also stated she did not eat breakfast because they always served pork with no alternatives. She stated her concerns were expressed to previous management, but nothing was done. In an interview on 3/26/5 at 11:57 AM, Resident #3 stated he was on a mechanical soft diet and was not satisfied with the food at the facility because it was not appetizing and there was never an alternative meal available. Resident #3 stated he was allergic to eggs and did not eat pork, so for breakfast he would just eat cold cereal. He stated he would also eat cold cereal for lunch and dinner if he did not like what was being served. In an observation and interview on 3/26/25 at 12:30 PM, revealed Resident #3 was eating lunch in the dining room. His tray consisted of mechanical soft breaded chicken breast with beans and coleslaw. Resident #3 stated the chicken was dry and he could not eat it. He stated the kitchen was serving pulled pork for lunch and he did not eat pork and was told the chicken was the only alternative available. Resident #3 stated he was just going to eat cold cereal. The Dietary Supervisor was called over and he offered to add gravy to the chicken; however, Resident #3 declined. In an observation and interview on 3/26/25 at 12:35 PM, revealed Resident #4 was eating a salad in her room. She stated she could not eat the lunch that was being served because it was pulled pork, and she could not eat it and was not offered an alternative. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 3/26/25 at 2:10 PM, the Dietary Supervisor stated he worked at the facility for about 4 weeks. He stated there was a budgeting issue at the facility that did not allow him to order all the food items needed to provide a proper alternative menu or All Day Menu. The DS stated he purposely went over budget with his most recent order to ensure there were some alternative options available that included chicken tenders, lunch meat, and peanut butter and jelly. The DS stated the facility did not have many alternative options for breakfast if a resident did not eat pork or eggs. He stated an option could be to offer hot or cold cereal and cottage cheese or chicken for protein. The DS stated turkey bacon and sausage were not an available alternative, and he understood that cereal did not offer a lot of nutritional value. The DS stated he did the best he could to accommodate all preferences and diets. He stated his concerns were brought to management, but he did not receive any support and received push back regarding the budget. The DS also stated the communication between the nursing staff and kitchen staff was not good and the residents would be the ones knocking at the kitchen door telling them what they wanted. The DS stated previous nursing management would tell the kitchen to just give the residents what they wanted and whatever was available. He stated that was not appropriate for residents who required special diets. The DS stated he hoped the investigation would cause management to give him the support he needed to improve the facility's menu and alternative options. In an interview on 3/26/25 at 2:30 PM, the Operations Manager stated he was unaware of the DS's concerns regarding the budget and not having support from management. He stated the facility did not currently have an All Day Menu but that was something they were working to implement. In an interview on 3/27/25 at 5:25 PM, with the Operations Manager, Clinical Resource and DON, the Clinical Resource stated residents' food preferences, allergies and special diets were discussed during the care plan meetings and the DS was a part of the meetings. The Operations Manager stated the DS took the information and entered it into a system that generated the meal tickets so that all kitchen staff would be aware when preparing the meals. The Clinical Resource stated any changes to a resident's diet was expected to be documented on a dietary form and communicated to the kitchen. The Clinical resource stated he was unaware that Resident #3 had an allergy to eggs, but he would inform that MD and, in the meantime, add it as a self-proclaimed allergy in his dietary notes so they would not be served to the resident. The Administrator stated he would work with the DS to ensure alternative food options were available to better accommodate residents' preferences. In an interview on 3/28/25 at 12:25 PM, CNA F stated she worked at the facility since 11/2024. She stated the CNAs were responsible for passing out all meal trays and ensuring the residents received the correct food according to their diets. CNA F stated there was not an All Day Menu prior to this date and residents did not always have an alternative meal available. She stated there were times when staff would go to the store to get food alternative food for residents who did not prefer what was being served. The facility's policy on food and nutrition services regarding alternative meals was requested from the Operations Manager on 03/26/25 at 5:16 PM and he stated the facility did not have one.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054 Based on observation, interview, and record review the facility failed to ensure that residents with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing for 2 residents (Resident #1 and Resident #2) of five residents reviewed for pressure ulcers. 1. The facility failed to document wound care treatments as ordered by the physician in February 2025 to Resident #1's right heel for 7 occurrences and to Resident #1's coccyx (tailbone) for 4 occurrences. 2. The facility failed to document wound care treatments as ordered by the physician in February 2025 to Resident #2's right heel for 7 occurrences and to Resident #2's sacrum (bone at base of spine)/coccyx for 11 occurrences. In [DATE], the facility failed to provide wound care treatments as ordered by the physician to Resident #2's left heel for 2 occurrences, right ankle for 2 occurrences, right heel for 1 occurrence, and sacral/coccyx for 7 occurrences. These failures could place all residents with wounds at risk for worsening wounds and/or infections. Findings included: 1. Record review of Resident #1's face sheet, dated [DATE], reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included: type II diabetes (body's inability to control blood glucose), hypotension (low blood pressure), dementia (loss of memory and thinking abilities), pressure ulcers, hx of urinary tract infection, hx of bacterial infection, hx of fracture of vertebrae (back fracture), and acute kidney failure. Record review of Resident #1's Nursing Home PPS MDS Assessment, dated [DATE], reflected Resident #1 had a BIMS score of 05, which indicated severe cognitive impairment. Further record review of the document reflected, under Section M - Skin Conditions, Resident #1 was at risk of developing pressure ulcers and was receiving ulcer treatment to feet, that included dressings. Record review of Resident #1's Care Plan, revised on [DATE], reflected the resident had friction to the coccyx area r/t immobility. Interventions included: Encourage good nutrition and hydration in order to promote healthier skin. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Further review of the document reflected there were no interventions for wounds of Resident #1's right heel. Record review of Resident #1's TAR, dated ,d+[DATE], reflected the following orders: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Right Heel: Clean area with NS, Pat dry. Apply Xeroform (medicated gauze dressing) and dry dressing until resolved. Every day shift. Order Date: [DATE]; D/C Date: [DATE]. Further review of the document reflected there were no signoffs for completion of the treatment on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE], and ,d+[DATE]. -Apply triad (wound paste) to buttocks every shift (day and night). Order Date: [DATE]; D/C Date: [DATE]. Further review of the document reflected there were no signoffs for completion of this treatment on , d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE]. Record Review of Resident #1's progress notes . [DATE]-[DATE],reflected there was not a note documenting why the treatments were not signed off on. Record review of Resident #1's surgical note by the Wound Care Physician, dated [DATE], reflected in part the following: Reason for visit: Consultation and evaluation of wounds located at the coccyx and right heel. Change in patient health: No change since last visit. . Wound -Location: coccyx -Etiology: friction -Signs of infection: none -Procedure performed: none -Dressing used: Triad Wound description -Odor: none -Exudate: scant , serous (moist, watery) -Peri wound (skin surrounding a wound): stable -wound edge: friable (brittle, dry) -Pain: ,d+[DATE] (measurement indicating mild pain) -wound base is 20% dermis (middle layer of skin), 80% epithelium (outer most layer of skin) - epithelium dark and soft (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Tissue types by percentage: 0% slough (non-viable tissue), 0% granulation (soft pink, red tissue), 0% necrotic tissues (death of cells in tissue), 0% hypergranulation (overgrowth of tissue), 0% eschar (dead, thick tissue), 100% epithelial tissue (outer most layer of skin). Size -Length: 10.7 cm -Width: 7.5 cm -Depth: utd -wound area: 80.25 cm^ 2 Wound progress: wound has increased in size. Wound -Location: right heel -Etiology: friction -Signs of infection: none -Procedure performed: none -Dressing used: xeroform (wet medicated dressing), dry dressing Wound description -Odor: none -Exudate: scant, serous (moist) -Peri wound: stable -wound edge: epithelializing (body's process of regenerating new outer most layer of skin) -Pain: ,d+[DATE] -Tissue types by percentage: 0% slough (non-viable tissue),100% granulation (soft pink, red tissue), 0% necrotic tissues (death of cells in tissue), 0% hypergranulation (overgrowth of tissue), 0% eschar (dead, thick tissue), 0% epithelial tissue (outer most layer of skin). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Size -Length: 0.5 cm -Width: 1.2 cm -Depth: 0.1 cm -wound area: 0.60 cm^2 Wound progress: wound has decreased in size. . 2. Record review of Resident #2's face sheet, dated [DATE], reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included: schizophrenia (disorganized thinking and behavior), pressure ulcers, paraplegia (type of paralysis that affects lower part of body), acute kidney failure, and hypertension (high blood pressure). Record review of Resident #2's Quarterly MDS Assessment, dated [DATE], reflected Resident #2's BIMS score was not documented. Further record review of the document reflected, under Section M - Skin Conditions, Resident #2 was at risk of developing pressure ulcers and had 1 stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer with treatments that included a pressure reducing device for bed and pressure ulcer care. Record review of Resident #2's Care Plan, revised on [DATE], reflected the resident had potential for pressure ulcer development r/t Hx of ulcers, immobility, and refusal of wound care at times. Interventions included: Monitor nutritional status. Serve diet as ordered, monitor intake and record. Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration noted during bath or daily carte. Requires pressure relieving/reducing device on (bed) low loss air mattress. Turn and reposition as tolerated, Use enhanced barrier precautions. Record review of Resident #2's TAR, dated ,d+[DATE], reflected the following orders: -Right Heel: Clean area with NS, Pat dry. Apply Xeroform (medicated gauze dressing) and cover with a dry dressing every day shift. Order Date: [DATE]; D/C Date: [DATE]. Further review of the document reflected there were no signoffs for completion of this treatment on ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], , d+[DATE], ,d+[DATE], ,d+[DATE]. -Sacral/Coccyx: clean with NS, pat dry, apply Santyl ointment (250 unit/GM), calcium alginate, collagen, and dry dressing daily and PRN every 12 hours for wound care. Order Date:[DATE]; D/C Date: [DATE]. Further review of this document reflected there were no signoffs for completion of this treatment at 8:00 AM- , d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE]; 8:00 PM- ,d+[DATE], , d+[DATE], ,d+[DATE], ,d+[DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675967	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northgate Plaza	2101 Northgate Dr Irving, TX 75062

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #2's progress notes . [DATE]-[DATE], reflected there was not a note documenting why the treatments were not signed off on. Record review of Resident #2's TAR, dated ,d+[DATE], reflected the following orders: - Clean wound to left heel, apply xeroform (medicated gauze dressing) and dry dressing every day shift. Order Date: [DATE]; D/C Date: [DATE]. Further review of the document reflected there were no signoffs for completion or refusal of this treatment on ,d+[DATE] and ,d+[DATE]. - Clean wound to outer right ankle, apply Santyl, collagen and cover with a dry dressing every day shift for wound care. Order Date: [DATE]. No D/C Date. Further review of the document reflected there were no signoffs for completion or refusal of this treatment on ,d+[DATE] and ,d+[DATE]. -Right heel: Clean with NS, pat dry. Apply xeroform (medicated gauze dressing) and cover with a dry dressing every day shift. Order Date: [DATE]; D/C Date: [DATE]. Further review of the document reflected there were no signoff for completion or refusal of this treatment on ,d+[DATE]. - Sacral/Coccyx: clean with NS, pat dry, apply Santyl ointment, calcium alginate, collagen, and dry dressing daily and PRN every 12 hours for wound care. Order Date: [DATE]; D/C Date: [DATE]. Further review of the document reflected there were no signoffs for completion of this treatment at 8:00 PM- ,d+[DATE]. - Sacral/Coccyx: clean with normal saline, pat dry, apply calcium alginate, collagen, and dry dressing daily and PRN two times a day for wound care. Order Date: [DATE]. No D/C Date. Further review of the document reflected there were no signoffs for completion of this treatment at 8:00 AM- ,d+[DATE], ,d+[DATE], , d+[DATE]; 8:00 PM- ,d+[DATE], ,d+[DATE], ,d+[DATE]. Record Review of Resident #2's progress notes . [DATE]-[DATE],reflected there was not a note documenting why the treatments were not signed off on. Record review of Resident #2's surgical note by the Wound Care Physician, dated [DATE], reflected in part the following: Reason for visit: Evaluation of wounds found at the sacrococcygeal, right lateral malleolus (outer side of ankle joint), and left heel. Change in patient health: No change since last visit. . Wound -Location: sacrococcygeal (base of spine where the sacrum bone meets the coccyx bone) -Etiology: pressure injury/ulcer- wound stage: 4 - pressure injury -Signs of infection: none (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Procedure performed: none -Dressing used: collagen, calcium alginate and dry dressing Wound description -Undermining: 1 cm at 12 o'clock -Odor: none -Exudate: moderate, serous (moist) -Peri wound: stable -wound edge: epithelializing (body's process of regenerating new outer most layer of skin) -Pain: ,d+[DATE] -Tissue types by percentage: 0% slough (non-viable tissue), 100% granulation (soft pink, red tissue), 0% necrotic tissues (death of cells in tissue), 0% hypergranulation (overgrowth of tissue), 0% eschar (dead, thick tissue), 0% epithelial tissue (outer most layer of skin). Size -Length: 6.0 cm -Width: 10.5 cm -Depth: 0.3 -wound area: 63.00 cm^2 Wound progress: wound has decreased in size. Wound -Location: right lateral malleolus -Etiology: pressure injury/ulcer- wound stage: 4 - pressure injury -Signs of infection: none -Procedure performed: none -Dressing used: Santyl/Collagen, dry dressing (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wound description -Odor: none -Exudate: mild, serous (moist) -Peri wound: stable -wound edge: epithelializing (body's process of regenerating new outer most layer of skin) -Pain: ,d+[DATE] -Tissue types by percentage: 10% slough (non-viable tissue),90% granulation (soft pink, red tissue), 0% necrotic tissues (death of cells in tissue), 0% hypergranulation (overgrowth of tissue), 0% eschar (dead, thick tissue), 0% epithelial tissue (outer most layer of skin). Size -Length: 1.5 cm -Width: 2.2 cm -Depth: 0.4 cm -wound area: 3.30 cm^2 Wound progress: wound has decreased in size. Wound -Location: left heel -Etiology: trauma -Signs of infection: none -Procedure performed: none -Dressing used: Collagen, dry dressing Wound description -Odor: none -Exudate: scant, serous (moist) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Peri wound: stable -wound edge: friable (brittle, dry) -Pain: ,d+[DATE] -Tissue types by percentage: 0% slough (non-viable tissue),100% granulation (soft pink, red tissue), 0% necrotic tissues (death of cells in tissue), 0% hypergranulation (overgrowth of tissue), 0% eschar (dead, thick tissue), 0% epithelial tissue (outer most layer of skin). Size -Length: 2.0 cm -Width: 1.5 cm -Depth: 0.2 cm -wound area: 3.00 cm^2 Wound progress: wound has increased in size. . In an interview on [DATE] at 9:25 AM, Resident #1's family stated the resident resided at the nursing facility for about 4 years and there were concerns with the care throughout the stay; however, the resident wanted to remain there. The family stated different family members visited Resident #1 almost daily and were active in his care planning. The family stated on the morning of [DATE], the family could see on the video monitor in Resident #1's room that something was wrong with him, so they went up to the nursing facility. The family stated Resident #1 was unarousable and they demanded that 911 be called. She stated Resident #1 was transported to the local hospital and was diagnosed with severe sepsis from a UTI and wound infection . The family stated the infection was too severe and hospice was the only option. The family stated they agreed to transfer Resident #1 to a hospice center, and he expired on [DATE]. In an observation and interview on [DATE] at 2:30 PM, revealed Resident #2 was lying in his reclined wheelchair. He stated that he preferred to lie in his wheelchair instead of the bed sometimes. Resident #2 was clear thinking and able to participate in the interview. He stated he was well and denied currently being in pain. Resident #2 stated the nurse always gave him pain medication before doing wound care. He stated he was satisfied with wound care and that his wounds were healing. Observation of Resident #2's left heel and right ankle revealed the wounds were dressed and dated [DATE]. The wound on right heel was healed. Observation of LVN E providing wound care revealed Resident #2's wounds did not have any signs of infection or non-healing . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 3:00 PM, LVN E stated she was hired as the wound care nurse in ,d+[DATE] and worked day shift, Monday-Friday. She stated Resident #2 had pressure wounds to both heels, the right ankle, and on his hip area. LVN E stated Resident #2's wounds were healing well although he sometimes refused wound care. She stated she had a good rapport with Resident #2 and could convince him to comply with wound care. LVN E stated there were currently no concerns with Resident #2's wounds. In an interview on [DATE] at 3:17 PM, LVN E stated she worked with Resident #1 before he discharged and she recalled him receiving treatment for a pressure wound on his right heel and coccyx that had some small areas that were dark; however, most of the wound was beefy and pink with healing tissue. She stated she last rounded on Resident #1 with the Wound Care MD on [DATE] and there were no signs of infection to either wound. LVN E stated the Wound Care MD wanted to debride the wound on Resident #1's coccyx but he was waiting for it to soften more. She stated the Wound Care MD did not seem to have any major concerns for Resident #1's wounds. In an interview on [DATE] at 3:30 PM, the Wound Care MD stated his last round with Resident #1 was on [DATE]. He stated Resident #1's wound on his coccyx had no eschar and no signs of infection. The Wound Care MD stated the wound needed to be debrided but it needed to soften a little more. He stated a debridement would have allowed him to see deeper into the wound; however, when he felt the wound, it did not feel squishy which indicated the tissue underneath was stable and there were no signs of infection. He stated he ordered an air mattress for Resident #1 to relieve more pressure and encourage healing, but there were no significant concerns for any of the resident's wounds. Attempted interview on [DATE] at 11:28 AM with LVN L, who worked day shift and was responsible for providing wound care on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE], was unsuccessful due to no response to call. Attempted interview on [DATE] at 4:06 PM with LVN L, who worked day shift and was responsible for providing wound care on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE], was unsuccessful due to no response to call. In an interview on [DATE] at 4:15 PM, the Operations Manager stated the previous wound care nurse quit without notice at the beginning of ,d+[DATE]. He stated the facility was without a designated wound care nurse until [DATE] and the floor nurses were responsible for completing daily wound care for their residents under the direction of the former DON and ADON. In an interview on [DATE] at 7:10 PM with the Clinical Resource and DON, the Clinical Resource stated the Wound Care Nurse/LVN E was responsible for providing all wound care Monday-Friday. He stated the floor nurses were responsible for providing wound care to their assigned residents during the weekends and if the Wound Care Nurse/LVN E was not at the facility. The Clinical resource stated the expectation was for the nurses to sign off on the TAR immediately after treatment was completed. He stated there were also codes to sign off with if the resident refused care. The Clinical Resource stated not signing the TAR could indicate that treatment was not provided which would place the residents at risk of infection, delay in wound healing and worsening of condition. The DON stated she had just started working at the facility about 5 days ago; however, she was working with the Clinical Resource to audit charts and re-educate nursing staff on the importance of documentation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Attempted interview on [DATE] at 11:21 AM with LVN L, who worked day shift and was responsible for providing wound care on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE], was unsuccessful due to no response to call. In an interview on [DATE] at 12:00 PM, RN C stated she worked at the facility since ,d+[DATE]. She stated she worked 6p-6a on a rotating schedule. RN C stated she worked on [DATE], [DATE], [DATE], [DATE], and [DATE]. RN C stated she provided wound care to Resident #1 and Resident #2 during those days, but she could not recall the exact days. RN C stated although it was never formerly communicated to the nurses by the previous DON, the floor nurses knew they were responsible for doing wound care during the weekends and any day when LVN E was not scheduled to work. RN C stated it was protocol to sign the residents' TAR immediately after completing wound care. She stated if the resident refused wound care, they still had to sign the TAR and code it for a refusal. RN C stated she always signed the TAR, but it was possible that she got busy and forgot to sign on some days. RN C stated it was important to sign the TAR to show that treatment was completed. In an interview on [DATE] at 12:00 PM, LVN J stated she worked for the facility for about a month, 6a-6p on a rotating shift. She could not recall the dates she worked; however, she stated she worked some weekends and was responsible for doing wound care on those days. LVN J stated she usually signed the TAR after completing wound care, but some days were hectic, and she would forget to sign. LVN J stated she always provided wound care for her assigned residents even if she forgot to sign the TAR. However, she stated it was important to sign the TAR to show that the wound care was completed. Record review of the facility's policy titled Wound Care and Treatment Guidelines, revised ,d+[DATE], reflected in part the following: Policy: It is the policy of this facility to provide excellent wound care to promote healing. Procedures: . 13. Documentation of the treatment should be done immediately after the treatment. .