

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675967	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER The Eden of Las Colinas		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that the residents' environment remained free of hazards as was possible for three of eight residents (Residents #2, #3 and #6) reviewed for accident hazards. The facility failed to ensure that Resident #2 did not have a container of Sani-wipes germicidal wipes on her shelf and a Hoyer-lift stored in her room on 07/15/2026. The facility failed to ensure that Resident #3 did not have Febreze aerosol spray can, Sani-wipes germicidal wipes and Febreze fabric freshener spray bottle in her room on 07/15/26. The facility failed to ensure that Resident #6 did not have disinfectant spray can in her room on 07/15/26. These deficient practices placed the residents at risk for accidental injury, exposure to hazardous chemicals and misuse of facility equipment. Findings included: Record review of Resident #2's Face Sheet, dated 07/15/2026, revealed a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with Cerebral palsy (non-progressive neurological disorders caused by brain damage which permanently affects body movement, posture, and muscle coordination) and Seizures (sudden, uncontrolled surge of electrical activity in the brain). Record review of Resident #2's Quarterly MDS Assessment, dated 06/20/26 revealed a BIMS score of 12 (Moderate cognitive impairment). The Quarterly MDS Assessment indicated that the resident is Dependent to require Substantial / Maximal assistance with most ADLs. Record review of Resident #2's Comprehensive Care Plan, dated 01/06/26 last revised 05/25/26 revealed the resident is at risk for impaired cognitive function and thought processes related to paranoid schizophrenia (condition where a person has trouble knowing what is real and what is not), bipolar (extreme, cyclical shifts in mood, energy, and activity levels). During an observation and interview on 07/15/26 at 10:17 a.m., Resident #2 had a can of Sani-cloth germicidal disposable wipes on her nightstand and a Hoyer-lift parked in her room. She stated that she did not bring in the Sani-wipe in her room, she stated that she does not remember who brought it into her room, but it was a staff. She stated that she thought they used it to clean her bed and left it on her nightstand. She stated that the Hoyer-lift was used to transfer her from her chair to her bed last night and they left it in the room. She stated she prefers that they did not store the Hoyer-lift in her room. Record review of Resident #3's Face Sheet, dated 07/15/2026, revealed a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with Stimulant use, in remission and Personal History of other mental behavioral Disorder. Record review of Resident #3's Quarterly MDS Assessment, dated 07/08/26 revealed a BIMS score of 14 (no cognitive impairment). The Quarterly MDS Assessment indicated that the resident is Independent to require setup clean-up assistance with most ADLs. Record review of Resident #3's Comprehensive Care Plan, dated 04/08/26 revealed the resident is at risk for Delirium or an acute confusional episode r/t fluctuations in ammonia levels due to cirrhosis of the liver. During an observation and interview on (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Residentcare equipment includes, but is not limited to, equipment used in the completion ofthe activities of daily living		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary comfortable environment for residents' staff and the public for 1 of 4 hall shower rooms (300 Hall shower room) and 2 of 8 (Residents #1 and #4) reviewed for environment. The facility failed to ensure that the shower room in 300 hall was clean and in sanitary condition on 07/15/26. The facility failed to ensure that the trash can in Resident #1's room had trash liners 07/15/26. The facility failed to ensure that the trash can in Resident #4's room had trash liners 07/15/26. This failure could place residents at risk for diminished quality of life. Findings included: Record review of Resident #1's Face Sheet, dated 07/15/26, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with Need for Assistance with personal care. Record review of Resident #1's Quarterly MDS Assessment, dated 04/22/2026, revealed a BIMS score of 07 (severe cognitive impairment). It revealed she needs substantial / maximal assistance with Toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear. During an observation on 07/15/26 at 9:33 a.m. it was observed that the trash can in Resident #1's room had no liner in it. Record review of Resident #4's Face Sheet, dated 07/15/26, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness and muscle wasting and atrophy (loss of muscle leading to its shrinking and weakening). Record review of Resident #4's Quarterly MDS Assessment, dated 04/22/2026, revealed that the resident had two unstageable pressure injuries and one stage 4 pressure ulcer which was present on admission and was coded for risk of developing pressure ulcers/injuries. During an observation on 07/15/26 at 9:40 a.m., it was observed that the trash can in Resident #4's room had no liner in it. During an observation on 07/15/26 at 10:17 a.m., it was observed that the shower room in the 300 hall had Molded/rusted shower seat, shower seat peeling off at the bottom, used gloves, wash clothes, plastic bottles, pillows, broken bedside table frame, old shower head, used tissue paper and plastic wrappings were scattered on the shower room floor. It was observed that the trash can had trash in it but had no liner in it. The toilet seat was observed with a stain on it. Personal belongings and drinks were observed on a bedside table and chair in the shower room. During an interview on 07/15/26 at 3:15 p.m., the Maintenance/housekeeping director stated that Housekeeping makes sure that the shower rooms are cleaned; he stated that CNAs make sure they pick up and put things in the trash when they shower residents. Housekeeping check the shower rooms daily in the morning, the showers in the residents' rooms are cleaned daily as well when they do rounds. She stated the housekeeping did not pay attention to the shower room on the 300 hall. He stated that the old shower head that was left there was changed 07/13/26, that the maintenance helper got distracted and forgot about it. He stated that they will do a deep clean today, he stated that they deep clean the shower rooms weekly and probably missed a few things. He stated that there is no log to track the cleaning of the shower rooms, but he can make one. He stated that it is important to have a log to keep a record of whether the shower room is deep cleaned or not. He stated that not deep cleaning the shower room can be a cause of cross-contamination and can spread disease to every resident who uses the shower. He stated that no personal items should be left in the shower room, he stated that they should be stored in the staff break room. During an interview on 07/15/26 at 3:49 p.m., CNA A stated that the housekeeping normally cleans the showers and the CNAs also clean after every shower. She stated that Housekeeping cleans daily. She stated that the shower rooms could be better cleaned. She stated (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that no drinks or personal items should be stored in the shower room because of contamination. She stated that a dirty shower room is not safe for the residents and is an infection control issue. She stated that the resident could get infected in a dirty bathroom, touching dirty surfaces is not good for the residents. She stated that no one wants to be in a dirty environment. During an interview on 07/15/26 at 5:12 p.m., the DON stated that her expectation is that the shower room should always be clean, the CNAs should pick up after each shower and that housekeeping sanitizes at the end of each day and that no personal items should be in the shower. She stated that each staff is able to log a maintenance concern to maintenance personnel. She stated that on the daily rosters each department head has a section of rooms including the showers and trash liners are inspected and any issues the residents are having are addressed daily. She stated that a dirty environment could make the facility not feel like a homelike environment and pose an infection control issue. She stated that not having a homelike environment could affect the residents' psychosocial health. During an interview on 07/15/26 at 6:10 p.m., the Administrator stated that her expectation is that the shower room should be clean and clear of debris. She stated that the CNAs who give showers and housekeeping are responsible for making sure the showers are cleaned. She stated that she is not sure of specifics of cleaning the shower, but that daily cleaning is done in the entire facility. She stated that no personal items should be stored in the shower but should be stored in the staff break room. She stated that this could cause cross contamination. She stated that for safety the showers should be clean since it's the resident's home. She stated that if the shower is not clean it puts the resident at risk for injury and infection and contamination. She stated that the trash can should be always lined up for proper disposal of items. She stated that if the trash is not line it could cause an unsanitary environment. She stated that an unsanitary environment could produce unpleasant smells, cause bacterial growth. Record review of the facility's Undated SOM F Resident Rights revealed: The facility must provide- S483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. S483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas. Orderly is defined as an uncluttered physical environment that is neat and wellkept. Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used in the completion of the activities of daily living		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with the comprehensive person-centered care plan and in accordance with professional standards of practice for one of eight residents (Resident #4) reviewed for quality of care. The facility failed to ensure that Resident #4's non-pressure wound left buttock and stage 4 pressure wound of right lateral ankle were cleansed in accord with best practice on 07/15/26. These failures could place the residents at risk of worsening pressure and non-pressure injuries and could result in a decline in health. Findings included: Record review of Resident #4's Face Sheet, dated 07/15/26, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness and muscle wasting and atrophy (loss of muscle leading to its shrinking and weakening). Record review of Resident #4's Quarterly MDS Assessment, dated 04/22/2026, revealed that the resident had two unstageable pressure injuries and one stage 4 pressure ulcer which was present on admission and was coded for risk of developing pressure ulcers/injuries. Record review of Resident #4's most recent Comprehensive Care Plan dated 06/23/26, revealed the resident had the potential for pressure ulcer development related to immobility incontinence of bowel and bladder; Has MASD TO LEFT BUTTOCK, right buttock AND SACRUM with intervention to CLEANSE WITH wound cleaner, PAT DRY, APPLY calcium alginate with silver COVER WITH DRY DSG. CHANGE DAILY AND PRN SOILAGE/DISLODGE MENT; Has pressure ulcer related to decreased mobility, fragile skin stage 4 right ankle with intervention to Administer treatments as ordered and monitor for effectiveness. Record review of Resident #4's Physician Order, dated 06/26/2026, revealed MASD TO LEFT BUTTOCK, CLEANSE WITH W/C, PAT DRY, APPLY sodium hypochlorite gel (anasept) WITH DRY DSG. CHANGE DAILY AND PRN SOILAGE/DISLODGE MENT. Every day shift; order dated 05/20/26 revealed PRESSURE INJURY STAGE 4 TO RIGHT LATERAL ANKLE: CLEANSE WITH WOUND CLEANSER, PAT DRY, APPLY MOISTENED HYDROFERA BLUE TOWOUND BED, COVER WITH DRY DSG. CHANGE 3X/WK (M,W,F) AND PRN SOILAGE/DISLODGE MENT every day shift every Mon, Wed, Fri CHANGE DRESSING IF SOILED OR DISLODGED During an observation and interview on 07/15/2026 at 11:03 a.m. - 11:52 a.m., LVN B and RN M were observed during wound care for Resident #4. LVN B cleaned Resident #4's non-pressure wound on the left buttocks (most contaminated area) to the inside of the wound (least contaminated area) using the same gauze and pressure wound to the right from the outside of the wound (most contaminated area) to the inside of the wound (least contaminated area) using the same gauze. They stated that using the same gauze to clean from outside the wound (dirty area) to inside the wound clean area will cross contaminate the wound. They stated the expectation for wound care is to clean from the inside to the outside. They stated that using proper wound cleaning techniques prevents wound contamination and infection. They stated that if the proper technique is not used it could prolong the healing process of the wound which will lead to increased chances of infection. They stated that DON is the one that makes sure that all wound care is provided as directed and a wound care team comes out to provide education on wound care. They stated that the sacral wound will be reported to the wound care provider. During an observation and interview on 07/15/26 at 11:03 a.m. A non-pressure wound of sacrum was observed and treated but was not documented as a wound site in the residents wound provider assessment. They stated Resident #4 had 3 wounds and not 4 that they know of, they stated that they have a wound doctor that comes in to assess the wounds. LVN B stated that the left buttock wound and the wound on the sacrum were the same wound but is healing and now had healed skin separating the sites. During an interview on (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	07/15/26 at 5:12 p.m. with the DON, she stated that she expects that the wound care should be performed in accordance with all infection control practices for wound cleaning patterns. She stated that this should be done to prevent infection. She stated that the wound should be cleaned from the cleanest to the dirtiest area. She stated that if the proper wound cleaning procedure is not followed, there could be a risk of cross contamination from the outer tissues (dirtiest area) to the inside tissue (cleanest area) which would prolong wound healing. During an interview on 07/24/26 at 1:40 p.m. with the wound care Nurse Practitioner, she stated that the wound on the left buttocks and the sacrum was one big wound that had healed skin separating the wound sites. She stated that it was one big wound initially and will be considered as one site the left buttocks and not 2 sites. Record review of the facility's policy and procedure 483.25 Quality of Care dated 03/2015, latest revision 4/2025, revealed: A resident having pressure injury(s) receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing. Promote the healing of pressure injuries that are present (including prevention of infection to the extent possible) Facility nursing staff will identify and document in the resident's clinical records, the condition and pressure injury risk factors related to the development of unavoidable pressure injury. This identification and implementation of a plan of care will begin at admission with the initial care plan and be completed throughout assessment process for developing a comprehensive plan of care. Ongoing Skin and Wound Assessments: A licensed nurse will assess/evaluate a resident's skin at least weekly. Areas of breakdown, excoriation, or discoloration, or other unusual findings (either initially identified at the time of admission or as new findings) must be documented in the nursing notes or on the appropriate weekly assessment form. (Skin Pressure Ulcer Weekly, Skin Ulcer Non-Pressure Weekly, or Skin Evaluation - PRN/Weekly) A licensed nurse will assess/evaluate at least weekly each area of alteration/injury, whether present on admission or developed after admission, which exists on the resident. This assessment/evaluation should include but not be limited to: i. Once an area of alteration in skin integrity has been identified, assessed, and documented, nursing shall administer treatment to each affected area as per the Physician's Order. j. Treatments per physician order, should be documented in the resident's clinical record at the time they are administered. a. Pressure Ulcer, Non-pressure Ulcer, and PRN/Weekly skin assessment/evaluation forms: If the clinical assessment/evaluation indicates a change in condition or decline in the wound, the assessing/evaluating nurse will notify the physician and create a narrative note documenting that notification. b. Weekly Skin Check Licensed nurse should document skin evaluations in accordance with this policy and document on the appropriate skin assessment/evaluation weekly/PRN form.		

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NAME OF PROVIDER OR SUPPLIER The Eden of Las Colinas		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure parental fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive care plan and the resident's goals and preferences for 1 (Resident #5) of 4 residents reviewed for PICC lines (Peripherally Inserted Central Catheter). The facility failed to change the PICC line intravenous catheter (an intravenous catheter that is suitable for long term infusion therapy) dressing on Resident #5 for more than 7 days. These failures placed the residents at risk of infection or dislodgement. Findings included: Record review of Resident # 5's face sheet dated 07/15/26 revealed he was a [AGE] year-old-male admitted on [DATE] he was diagnosed with Infection and Inflammatory Reaction Due To Internal Right Knee Prosthesis (prosthetic joint infection). Record review of Resident #5's physician order dated 06/08/26 revealed an order for PICC Line Care: Change PICC Line Dressing Q 7 Days If Site Is Visible for Assessment. Change Dressing PRN If Wet, Soiled, Saturated or Loose. every day shift every Tue. Record review of Resident # 5's Care Plan dated 06/04/26 revealed the resident's Is on IV Antibiotic Therapy r/t Right knee prosthesis infection (06/04/26 to 07/30/26) with intervention to Administer medication as ordered and PICC line care per facility protocol. Record review Resident # 5's Medication Administration Record under Schedule for July 2026 revealed, PICC Line Care: Change PICC Line Dressing Q 7 Days If Site Is Visible for Assessment. Change Dressing PRN If Wet, Soiled, Saturated or Loose. every day shift every Tue. The MAR revealed an entry made for a PICC line dressing change on 07/07/26 and 07/17/26. Observation and interview on 07/15/26 at 2:13 p.m., revealed Resident #5 had a single lumen PICC line to the left arm with a dressing dated 07/06/26. The resident stated he is not sure how often the dressing on the PICC line is changed. During an interview on 07/15/26 at 5:12 p.m., the DON stated that the dressing is scheduled to be changed on the PICC line every seven days and as needed if soiled as it was ordered. She stated that this is done to prevent and decrease the risk of an infection. She stated that if the dressing is not changed as ordered it could lead to another infection. She stated that the nurse is responsible for making sure the dressing is changed and she is ultimately responsible for making sure they do so. Review of the facility's current Guidelines Central venous Devices revealed A transparent film dressing is the preferred type of central line dressing for ease of site assessment. This transparent film dressing is changed weekly and PRN soiling, contamination and non-occlusiveness (non-adherent).		