| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676080 | A. Building<br>B. Wing | 07/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Town Hall Estates Arlington, Inc. | 824 W Mayfield Rd<br>Arlington, TX 76015 |

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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to ensure residents were informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment for 1 resident (Resident #50) of 6 residents reviewed for informed consents. The facility failed to ensure Resident #50 was informed of the risks and benefits prior to being administered antipsychotic medications. This failure could place the residents at risk of receiving medications with side effects they do not wish. Findings include: Record review of Resident #50's undated admission Record reflected she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included fracture of her neck, and psychotic disturbance. Record review of Resident #50's admission MDS dated [DATE], reflected a BIMS score of 12 which indicated she had moderate cognitive impairment. Her Functional Assessment indicated she used a walker or wheelchair and required minimal assistance with her ADLs Record review of Resident #50's care plan, dated 6/05/25, reflected she had depression, Alzheimer's Disease, and was taking psychotropic medications. Record review of Resident #50's physician's orders reflected orders, dated 6/04/25, for Olanzapine Oral Tablet 5 MG (Olanzapine). Give 1 tablet by mouth at bedtime for mood. and Aripiprazole Oral Tablet 10 MG (Aripiprazole). Give 1 tablet by mouth one time a day for Depression Record review of Resident #50's June 2025 medication administration record reflected she began receiving Olanzapine Oral Tablet 5 MG and Aripiprazole Oral Tablet 10 MG on 6/05/25. Record review on Resident #50's consents reflected a consent for Aripiprazole Oral Tablet 10 MG for psychotic disturbance was signed by her responsible party on 6/28/25. There was no indication of the responsible party giving verbal consent. Record review of Resident #50's consents reflected a consent for Olanzapine Oral Tablet 5 MG for psychotic disturbance was signed by her responsible party on 6/28/25. There was no indication of the responsible party giving verbal consent. In an interview on 7/3/25 at 5:15 PM the DON stated the ADONs were responsible for ensuring consents for antipsychotic medications were signed prior to the medication being administered. She stated the risk of the resident receiving antipsychotic medications without being informed of the risks, benefits, and side-effects of the medication could be the resident having unexpected outcomes from the medication. In an interview on 7/3/25 at 5:30 PM the ADON stated consents for antipsychotic medications needed to be signed prior to the resident receiving the first dose. She stated she did not recall when Resident #50's consents were signed, but often times they got consent over the phone from the responsible party and then had them sign the paperwork on their next visit. She stated the consent should be dated the date a verbal consent was given. In a phone interview on 7/3/25 at 5:38 PM Resident #50's Responsible Party stated they did not recall signing the consent for antipsychotic medications or talking about it over the phone with anyone. They stated there was so much paperwork signed and so many phone calls he may have given consent and not remembered it. He had no concerns about the resident taking the medications because she had taken them before being admitted to the facility. On 7/3/25 at 5:50 PM the Administrator was unable to supply a policy on Consents prior to exit. He stated he did not think there was a policy addressing consents specifically. |

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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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary and comfortable interior for 1 of 21 residents (Residents #48) reviewed for environment. The facility failed to ensure Residents #48's bed curtain was free from a dried brown substance. This failure could affect any resident and place them at risk for not having a sanitary homelike environment. Findings included: Record Review of Resident #48's Quarterly MDS, dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #48's MDS also reflected diagnoses of non-Alzheimer's dementia (a range of neurodegenerative and other disorders that cause cognitive decline, distinct from Alzheimer's disease), anxiety, and chronic kidney disease stage 2 (signifies a mild decrease in kidney function alongside evidence of kidney damage). Resident #48's MDS also reflected a BIMS of 6 (meaning severe cognitive impairment). Resident #48's MDS also reflected Resident #48 required supervision for ADL's. Observation and interview on 07/01/25 at 10:37 AM with CNA H of Resident #48's room revealed the privacy curtain had a dried brown substance on it. The substance area was approximately .5 cm x 1 cm. CNA H stated that it was her responsibility to tell maintenance when a resident's privacy curtain became dirty. CNA H said that when aides reported dirty privacy curtains to maintenance, maintenance would remove the dirty privacy curtains and take them to the laundry. CNA H revealed it was important to keep residents' privacy curtains clean to help prevent infections. CNA H stated that the facility policy was to keep privacy curtains clean and when resident's privacy curtains became dirty, staff were to report it to the maintenance director. Observation on 07/02/25 at 04:03 PM of Resident #48's room revealed the privacy curtain had a dried brown substance on it. The substance area was approximately 0.5 cm x 1 cm. Interview on 07/02/25 at 04:14 PM with LVN I revealed that dirty privacy curtains should be reported to the maintenance department who would take the curtain down and send it to the laundry. LVN I stated the importance of clean privacy curtains was to prevent infection and ensure residents' dignity. LVN I said it was all staff's responsibility to report dirty privacy curtains. Interview on 07/03/25 at 9:28 AM with the facility Director of Maintenance/Housekeeping revealed soiled privacy curtains should be reported to him. The Director of Maintenance/Housekeeping stated that when dirty privacy curtains were reported to him, he would ensure that they were removed, washed, and hung back up the same day. The Director of Maintenance/Housekeeper said that it was everyone's responsibility to report soiled curtains. He also said that if the curtains are not reported, the resident would have to continue to view the dirty curtains. The Director of Maintenance/Housekeeper revealed that no one had reported the dirty curtains to him. Interview on 07/03/25 at 9:46 AM with CNA J revealed that staff should report to their nurse if they saw a dirty privacy curtain. CNA J stated that the importance of clean curtains was for good health and avoid the spread of germs. CNA J said that when the maintenance department got the request, they should remove dirty privacy curtains, wash them, and hang them back up. CNA J stated that if the nurse would not report the dirty curtains to the maintenance department, she would notify her ADON. Interview on 07/03/25 at 10:41 AM with the Housekeeper revealed that if she saw a dirty privacy curtain, she would report it to her supervisor. Interview on 07/03/25 at 12:43 PM with Resident #48 revealed that the dirty privacy curtain did not interrupt her daily life. Resident #48 stated that she didn't see well, so she could not see the brown substance on her privacy curtain. Record Review of the facility's Use of Privacy Curtains in Resident Rooms policy, undated, reflected: .Procedures .5. Infection Control-Curtains must be laundered or replaced according to infection control guidelines or immediately if soiled |

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| F 0635<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide doctor's orders for the resident's immediate care at the time the resident was admitted.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676080 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/03/2025 |
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| F 0635<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure there were physician orders for a resident's immediate care at the time the resident was admitted for 1 of 5 (Resident #49) reviewed for admission orders.The facility failed to obtain physician orders for Resident #49's immediate care when he admitted to the facility on [DATE] with a Stage 2 pressure ulcer on his coccyx, which resulted in the resident not receiving physician-ordered wound treatment from 06/02/25-06/24/25 and the Stage 2 pressure ulcer worsening to a Stage 4. An IJ was identified on 07/02/25. The IJ template was provided to the facility on [DATE] at 4:10 PM. While the IJ was removed on 07/03/25, the facility remained out of compliance at a scope of isolated and a severity level potential for more than minimal harm that is not Immediate Jeopardy, due to the facility's need to implement corrective systems.The failure placed residents at risk for medical complications, wound deterioration, infection, and death. Record review of Resident #49's admission MDS assessment, dated 06/09/25 and signed off as completed by the DON on 06/15/25, reflected the resident was a [AGE] year-old male, who admitted to the facility from the hospital on [DATE]. The resident's active diagnoses included malnutrition, pneumonia, respiratory failure, anxiety disorder, essential hypertension (high blood pressure), and generalized muscle weakness. Resident #49 had moderate cognitive impairment with a BIMS score of 11. The resident required supervision or touching assistance with eating, and he had an admission weight of 128 pounds. The resident required substantial/maximal assistance with toileting hygiene, and he was frequently incontinent of bowel and bladder. The MDS further reflected the resident admitted to the facility with one Stage 2 pressure ulcer, and he was supposed to have pressure ulcer/injury care and a pressure reducing device for bed.Record review of Resident #49's Clinical Admission Initial Assessment, dated 06/02/25, completed by RN L reflected the following questions were answered: .24. Skin Issue - Pressure ulcer/Injury27. Pressure ulcer staging - Stage 2 Pressure Ulcer/Injury: Partial thickness skin loss with exposed dermis[BR5] [LO6] (the skin)35. Acquired - Present on admission36. Onset - Unknown46. Presence of wound pain - No53. Staged by: In-house nursing59. Length (cm) - 360. Width (cm) - 561. Depth (cm) - 0 Record review of Resident #49's Progress notes on 06/02/25 21:50 by LVN K reflected the following Skin: Skin warm & dry, skin color WNL and turgor (skin's elasticity) is normal. Skin Issue: #001: New skin Issue. Location: Coccyx (the final segment of the vertebral column). Laterality / Orientation: Medial (closer to the midline of the body). Issue type: Pressure ulcer / injury. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound was present on admission. It is unknown how long the wound has been present. Painful: No. Staged by: In-house nursing. Length (cm): 3 Width (cm): 5 Depth (cm): 0#002: New skin Issue. Location: Left antecubital space (the triangular area on the inner side of the left elbow). Additional location information: Bruises Issue type: Bruising (contusion). Wound was present on admission. It is unknown how long the wound has been present.#003: New skin Issue. Location: Right anterior (nearer the front) elbow. Laterality / Orientation: Right. Additional location information: Bruises Issue type: Bruising. Wound was present on admission. It is unknown how long the wound has been present. Record review of Resident #49's Progress notes from 06/02/25 through 06/24/25 by LVN K, RN L, LVN M, RN Z, and LVN AA reflected the following notes: Skin: Skin Issue: #001: Skin issue has not been evaluated. Location: Coccyx. Laterality / Orientation: Medial. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound was present on admission. It is unknown how long the wound has been present. Staged by: In-house nursing. #002: Skin issue has not been evaluated. Location: Left antecubital space. Additional location information: Bruises Issue type: Bruising. Wound was present on admission. It is unknown how long the wound has been present. #003: Skin issue has not been evaluated. Location: Right anterior elbow. Laterality / Orientation: Right. Additional location information: Bruises Issue type: Bruising. Wound was present on admission. It is unknown how long the wound has been present. There was no documentation of Wound Care Physician, Nurse Practitioners were made aware of Resident #49's pressure wound. No documentation of any wound care provided to Resident #49.Record review of Resident #49's Nurse Practitioner Visit Notes dated 06/10/25 reflected: Chief complaint - Skilled care visit - Nurse reports abnormal lab results and request to review lab. Review of systems: Skin - neg for rash Objective: Physical Examination: Skin: Warm and Dry. There was no documentation in the Nurse Practitioner's notes reflecting the resident's pressure ulcer was observed. Record review of Resident #49's Initial Wound Evaluation & Management Summary dated 06/25/25 reflected |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received necessary treatment and services, consistent with professional standards of practice to promote wound healing and to prevent new pressure ulcers from developing for one of five residents (Resident #49) reviewed for pressure ulcers. The facility staff failed to notify the Wound Care Physician of Resident #49's Stage 2 pressure ulcer on his coccyx upon admission. Resident #49 was not provided with wound care treatment from 06/02/25 - 06/25/25 which resulted in resident's pressure ulcer worsening from a Stage 2 to a Stage 4. An IJ was identified on 07/02/25. The IJ template was provided to the facility on [DATE] at 4:10 PM. While the IJ was removed on 07/03/25, the facility remained out of compliance at a scope of isolated and a severity level potential for more than minimal harm that is not Immediate Jeopardy, due to the facility's need to implement corrective systems. These failures could place residents at risk for new development or worsening of existing pressure injuries, pain, decreased quality of life, and hospitalization.Findings included: Record review of Resident #49's admission MDS assessment, dated 06/09/25 and signed off as completed by the DON on 06/15/25, reflected the resident was a [AGE] year-old male, who admitted to the facility from the hospital on [DATE]. The resident's active diagnoses included malnutrition, pneumonia, respiratory failure, anxiety disorder, essential hypertension (high blood pressure), and generalized muscle weakness. Resident #49 had moderate cognitive impairment with a BIMS score of 11. The resident required supervision or touching assistance with eating, and he had an admission weight of 128 pounds. The resident required substantial/maximal assistance with toileting hygiene, and he was frequently incontinent of bowel and bladder. The MDS further reflected the resident admitted to the facility with one Stage 2 pressure ulcer, and he was supposed to have pressure ulcer/injury care and a pressure reducing device for bed. Record review of Resident #49's Clinical Admission Initial Assessment, dated 06/02/25, completed by RN L reflected Resident #49 admitted to the facility with a Stage 2 pressure ulcer that measured 3.0 cm x 5.0 cm x 0.0 cm. Record review of Resident #49's Progress Notes written by LVN K, dated 06/02/25 at 9:50 PM, reflected the following: Skin: Skin warm & dry, skin color WNL and turgor (skin's elasticity) is normal. Skin Issue: #001: New skin Issue. Location: Coccyx (the final segment of the vertebral column). Laterality / Orientation: Medial (closer to the midline of the body). Issue type: Pressure ulcer / injury. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound was present on admission. It is unknown how long the wound has been present. Painful: No. Staged by: In-house nursing. Length (cm): 3 Width (cm): 5 Depth (cm): 0. Record review of Resident #49's Progress notes from 06/02/25 through 06/24/25 by LVN K, RN L, LVN M, RN Z, and LVN AA reflected they all used the same note in all their entries regarding Resident #49's pressure ulcer: Skin: Skin Issue: #001: Skin issue has not been evaluated. Location: Coccyx. Laterality / Orientation: Medial. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound was present on admission. It is unknown how long the wound has been present. Staged by: In-house nursing.There was no documentation in Resident #49's Progress Notes reflecting the Physician, Nurse Practitioner, or the Wound Care Physician had been made aware of Resident #49's pressure ulcer. There was also no documentation in the Progress Notes reflecting Resident #49 was receiving wound care nor was there documentation reflecting the resident was on a low air loss mattress. Record review of Resident #49's Nurse Practitioner Visit Notes dated 06/05/25 reflected the resident had a diagnosis of protein calorie malnutrition prior to his admission the facility in the hospital on [DATE]. Regarding the resident's skin, the Nurse Practitioner documented: .Physical Examination.Skin: No visible skin lesions or rashes noted in exposed BUE or BLE. There was no documentation in the Nurse Practitioner's notes reflecting the resident's pressure ulcer was observed nor was there an order for care/treatment of the pressure ulcer.Record review of Resident #49's Care Plan, initiated on 06/09/25, reflected Resident #49 was at risk for weight loss as evidenced by being a new admission and consuming less than 25% of meals with a poor appetite. Care Plans, initiated on 06/21/25, reflected: Resident #49 was at risk for skin breakdown; the resident had ADL deficits to include bed mobility, transfers, eating, toilet use, dressing, personal hygiene, and bathing; and the resident was incontinent of bowel and bladder. Record review of Resident #49's Initial Wound Evaluation & Management Summary dated 06/25/25 reflected the following exam completed: Stage 4 Pressure Wound Sacrum full thickness - Etiology (quality) Pressure, Stage 4, Wound Size (L x W x D): 4.0 c 4.0 x 0.8 cm, Surface Area: 16.00cm2, Infection Assessment: No |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services to prevent complications of enteral feedings for 1 of 1 resident (Resident #61) reviewed for enteral nutrition. The facility failed to follow Resident #61's physician's orders for enteral feeding. These failures could affect residents receiving enteral nutrition/hydration and place them at risk of health complications and decline in health. Findings included:Record review of Resident #61's Quarterly MDS, dated [DATE], reflected a [AGE] year-old female with an initial admit date of 01/30/25 and re-admit date of 06/10/25. Resident #61 had diagnoses of nontraumatic intracerebral hemorrhage in hemisphere, subcortical (a type of stroke where bleeding occurs within the brain's white matter, specifically in the area beneath the cortex of the cerebral hemispheres), gastrostomy status (refers to the presence of a gastrostomy tube, an artificial opening in the stomach for feeding or medication administration), diabetes mellitus (a group of diseases that result in too much sugar in the blood), and dysphagia following cerebral infarction (a common and serious swallowing difficulty complication following a cerebral infarction(stroke)). Record review also reflected Resident #61 could rarely or never be understood so a BIMS score could not be attained. Record review also reflected that Resident #61 also received nutrition via a feeding tube. Record review of Resident #61's care plan revised dated 06/10/25 reflected:Focus: Resident at nutrition and dehydration risk related to receiving feeding via G-tube secondary to Dysphagia. Formula: Glycerna, may use Osmolite. Goal: Resident will have adequate nutrition and fluid over the next 90 days. Interventions: Administer Tube Feeding as order by the MD. Check for residual q shift or as the physician orders. Check for tube placement q shift or as ordered by physician. Flush g-tube before and after meds as ordered by physician. H2O as ordered by the physician. Record review of Resident #61's physician order dated 06/11/25 revealed every shift for g-tube every shift Glucerna 1.5 via g-tube @50 ml[BR7] [LO8] /hr, (may use Osmolite 1.5) x 22 hours (off between 12PM and 2 PM) with water flushes 100 ml every 6 hours and every shift flush g-tube with 60 ml of H2O before and after medication administration. Observation on 07/02/25 at 11:01 AM revealed Resident #61 lying in bed watching television. Observation also revealed Resident #61's feeding pump was running at a rate of 60 ml/hr. Interview on 07/02/25 at 11:08 AM with LVN C revealed Resident #61's physician's order reflected the enteral feeding pump should be set at 50 ml/hr. LVN C stated that the pump was running incorrectly at 60 ml/hr. LVN C said that the enteral feeding pump rate should match the physician's order. LVN C then revealed the incorrect rate could create a risk of fluid overload which could then lead to aspiration, (which is the inadvertent inhalation of substances like food, liquid, or other materials into the lungs), instead of being swallowed properly. LVN C stated that it was his responsibility to verify residents' enteral feeding pump rates were the same as the physician's orders when making rounds. LVN C said he should report it to the ADON if he found a resident's enteral feeding pump was running at an incorrect rate. LVN C corrected the enteral feeding pump and notified ADON A. Interview on 07/02/25 at 05:05 PM with ADON A revealed she expected nurses to review the physician's order prior to entering the rate on the resident's enteral feeding pump. ADON A stated that the nightshift nurse started the enteral feeding pumps, but she expected the dayshift and evening shift to verify the orders when making rounds. ADON A said that the facility policy stated that the enteral feeding pump rate should match the physician's orders. ADON A revealed that the risk to the resident when the rate entered was more than the rate ordered was the resident's stomach getting too full, weight gain, etc. ADON A stated that a nurse should follow the chain of command and notify their ADON if they found an order entered wrong on an enteral feeding pump. ADON A stated that she was notified previously of the incorrect rate on Resident #61's enteral feeding pump. Interview on 07/02/25 at 06:14 PM with the DON revealed that she expected nurses to follow physician's orders when they set residents' enteral feeding pumps. The DON stated that it was the responsibility of all nurses to ensure their residents' orders were entered correctly on the enteral feeding pump and were checked by nurses when they made rounds. The DON said that the if a nurse found an enteral feeding pump set incorrectly, the nurse should notify their ADON. The DON revealed that residents risked fluid overload and excess calories when their enteral feeding pumps were set too at a faster rate than their physician's orders. Record review of the facility's Enteral Tube Feeding via Continuous Pump policy, revised March 2015, reflected: .General Guidelines .3. Check the enteral nutrition label against the order before administration. Check the following information: a. Rate of administration (mL/hour) ) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide or obtain dental services for each resident.<br><br>(continued on next page) |

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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) |
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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assist residents in obtaining routine and 24-hour emergency dental care for one (Residents #5) of three residents reviewed for dental services. The facility failed to follow up and schedule an appointment for resident to be seen by dentist so that she could receive dentures. This failure could affect residents by placing them at risk for oral complications, dental pain, and diminished quality of life. Findings included: Review of Resident #5's Quarterly MDS, dated [DATE], reflected the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included chronic kidney disease (longstanding disease of the kidneys leasing to renal failure), non-Alzheimer's dementia (a group of neurodegenerative disease that cause cognitive decline, but are distinct from Alzheimer's disease, diabetes mellitus (a group of diseases that result in too much sugar in the blood), and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). Record review also reflected a BIMS score of 7, indicating severe cognitive impairment. Resident #5's functional status indicated she required supervision or touching assistance in her ADLs. Her Oral/Dental Status did not indicate broken or loose-fitting dentures and no pain with chewing. Review of Resident #5's care plan, dated 7/15/24, reflected resident had a mechanical soft, low concentrated sweets diet. Review of Resident #5's care plan dated 05/06/25 also reflected: Focus-Resident has dental problems AEB: Edentulous (meaning no teeth)Goal-Resident will have no adverse effects from dental problems through the next review periodInterventions-Staff will assess oral status on admission, staff will provide oral care daily, staff will refer any dental problems to social services for follow up. Review of Resident #5's Progress Notes by the Social Worker, dated 05/21/25 at 1:07 PM, reflected SW reached out JPS and left voicemail to return call for dental referral. Review of Resident #5's weights revealed that resident had no weight loss since admission. Interview and observation on 07/02/2025 at 4:26 PM with Resident #5 revealed the resident had no lower teeth or upper teeth. Resident #5 stated that she had no dentures nor teeth. Resident #5 said that it bothered her having no teeth because she had to eat chopped meats and did not like eating it that way. Resident #5 stated that she desperately wanted dentures. The resident did not say how long she had been without teeth. Interview on 07/02/25 at 3:17 PM with the Social Services Director revealed that it was her responsibility to schedule dental appointments for residents. The Social Services Director stated Resident #5 was referred to a dental company by her hospital due to her income status. The Social Services Director stated she had not gotten around to calling the referred dental company and asking what documents needed to be sent over so that the appointment could be scheduled. The Social Services Director said that it was on her to do list. The Social Services Director stated that she was aware the resident and knew the resident had no teeth and was on a mechanical soft diet due to having no upper or lower teeth. The Social Services Director revealed that when she assisted residents who need dentures, she would check financing, check resourcing, then call the referred dental company. The Social Services Director stated that in this case, she had not had time to call the referred dental company in the past five weeks. The Social Services Director stated that having no teeth didn't affect Resident #5 because she has seen Resident #5 eat what she wants to eat. Interview on 07/03/25 at 12:05 PM with the Administrator revealed that it was the Social Services Director's responsibility to follow up on dental referrals. The Administrator stated if the Social Services Director did not follow up on referrals, it was ultimately his responsibility to follow up on the referral but did not reveal this process. The Administrator said that the importance of residents' dental appointments was so residents could enjoy their food and eating. Interview on 7/3/25 at 12:35 PM with LVN C revealed if a resident needed to see a dentist the nurses would communicate it to the Social Services Director. LVN C then stated that the Social Services Director would then put the resident's name on the dentist's list so they could be seen by the dentist the next time they came to the facility. LVN C also revealed that he would inform the doctor. And if the resident is in pain, LVN C would request pain medication. Record Review of Timeliness of Referral to Outside Vendors policy, dated 7/3/25, reflected:The designated staff member (e.g., Social Worker, DON, or Referral Coordinator) must contact the vendor within 3 business days of referral initiation. If the service is urgent, contact must be made within 24 hours, and documentation must reflect the urgency. Residents with no source of income, may require extended processing of referrals. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 676080 | A. Building<br>B. Wing | 07/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. in the facility's only kitchen. 1. The facility failed to ensure the refrigerator was maintained in a sanitary manner free from dark substances. 2. The facility failed to ensure food items stored in the freezer were properly discarded. This failure could place all residents at risk for food contamination and food borne illness. Findings included: Observation and interview on 07/01/25 at 9:01 AM with the Dietary Manager revealed a dark substance on the floor of the walk-in cooler. The dark substance was approximately 12 inches by 4 inches on the non-porous floor. The Dietary Manager stated that the substance had built up over the years and would not come off the floor. Therefore, nothing had been attempted in the past to clean the substance off the floor. The Dietary Manager said that the substance on the floor would not affect the residents' health because it was not touching anything. The Dietary Manager also revealed it was his responsibility to ensure the kitchen was clean and sanitary. Observation and interview on 07/01/25 at 9:06 AM with the Dietary Manager revealed a clear unlabeled and undated sealed plastic bag in the freezer was previously defrosted ground beef and re-frozen. The clear bag had a puddle of frozen blood from being previously thawed and re-frozen. The Dietary Manager stated that the previously defrosted ground beef should not have been in the freezer and should not have been re-frozen. The Dietary Manager said that if the ground beef was cooked and served, residents were at risk of food borne illnesses. The Dietary Manager revealed this meat had been put in the freezer by a new cook who was not aware this could be harmful to the residents. The Dietary Manager stated the new cook, who would not work the remainder of the week, had placed the thawed meat back into the freezer on the previous Sunday when he had not worked. Attempts were made to interview the staff member that placed the re-frozen meat in the freezer, but she did not work that week. The Dietary Manager stated he had not seen the meat in the freezer. The Dietary Manager stated that he in-serviced staff every Wednesday at 1:00 PM, and he would in-service his staff that afternoon regarding the issues found. The Dietary Manager said that he expected his cooks to know how to store, label, and date and regularly made rounds to ensure that items were not stored incorrectly. The Dietary Manager removed the previously defrosted ground beef from the freezer and disposed of it. Review of the facility's undated Receiving and Storage policy, reflected: Storage: All foods will be properly stored to preserve flavor, nutritive value, and appearance and to protect against foodborne illness 1. b. Do not refreeze a thawed product - cook and or use immediately . 7. Refrigeration units should be kept clean with spillage wiped up immediately and a thorough cleaning at least weekly |

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| | 676080 | A. Building<br>B. Wing | 07/03/2025 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>(continued on next page) |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 resident (Resident #50) of 7 residents observed for infection control. Staff failed to use the appropriate PPE when providing care for Resident #50 who was on EBP. This failure could place resident at risk of being infected with germs from another resident. Record review of Resident #50's undated admission Record reflected she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included fracture of the leg with surgical repair, dementia, and kidney failure. Record review of Resident #50's admission MDS, dated [DATE], reflected a BIMS score of 12, indicating she had moderate cognitive impairment. Her Functional Status assessment reflected she required some assistance with her ADLs. Record review of Resident #50's care plan, dated 6/17/25, reflected she was planned for right leg fracture, decreased ADL function, and isolation precautions related to surgical wound. Record review of the facility's Infection Control/Antibiotic Stewardship log revealed the facility had 14 residents on isolation for wounds, catheters, gastric tubes, and IV access. Resident #50 was on EBP because she had wounds as well as a urinary catheter. Observation on 7/01/25 beginning at 9:10 AM of the 100 and 200 Halls revealed seven residents with signage outside their rooms indicating they were on EBP. Observation on 7/01/25 at 9:15 AM revealed Resident #50 had signage on her door indicating she was on EBP. PPE was located in an alcove near her room. Observation on 7/02/25 at 11:21 the COTA transferred Resident #50 from her wheelchair to her bed using a slide board. The COTA was not wearing any PPE. Observation on 7/03/25 at 12:30 PM CNA-D and CNA-E transferred Resident #50 from her bed to her wheelchair, without wearing any PPE, using the mechanical lift. In an interview on 7/3/25 at 1:25 PM CNA-D stated she knew which residents were on isolation by the signage outside their room. The sign advised her what level of PPE was required to be worn when providing care to the resident. She stated she did not wear PPE while transferring Resident #50 because she did not normally work on the floor, and she was unfamiliar with the residents of that hall and she just forgot. She stated the risk of not wearing PPE was spreading infection from one resident to the other. In an interview on 7/3/25 at 1:45 PM CNA-E stated she did not notice the sign outside Resident #50's room, so she did not use any PPE. She stated she was called to that hall from where she normally works, and she was not familiar with the residents of that hall. She knew residents with the sign at the door meant she had to wear a gown and gloves. In an interview on 7/3/25 at 2:15 PM the COTA stated she did not know what it meant when a resident was on EBP. She stated she was aware of the signs on the resident rooms showing the wearing of gowns and gloves. She stated she just did not wear it as the resident was in a hurry to get back to bed. She stated the risk of not wearing the PPE was possibly spreading infections. In an interview on 7/3/25 at 2:20 PM CNA- F stated she did not know what EBP was, but she knew to wear a gown and gloves with residents who had the sign outside their room. She did not know the risk of not wearing the proper PPE. In an interview on 7/3/25 at 2:28 PM CNA-G stated EBP signs were placed outside the rooms of residents they were supposed to wear a gown and gloves when they were providing care to them. In an interview on 7/3/25 at 2:35 PM CNA-H stated she knew which residents were on EBP because the nurse would tell them, plus there was a sign outside their room. EBP required a gown and gloves to be worn. In an interview on 7/3/25 at 5:15 PM the DON stated EBP were put in place for any resident with a wound, IV, or any tube that was inserted. She stated signs were placed outside the room of those residents, and PPE was kept in an alcove on the hall. She stated the risk of not wearing the appropriate PPE was giving the resident an infection from another resident. The DON stated she or the Infection Preventionist perform in-services for staff on infection control and PPE usage. She stated there was no monitoring of staff to ensure PPE was being used. Record review of the facility's undated policy Infection Control reflected: Contact Precautions Use personal protective equipment (PPE) appropriately, including gown and gloves. Wear gown and gloves for all interactions that may involve contact with the resident or the resident's environment. |