STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676132	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trail Lake Nursing & Rehabilitation	7100 Trail Lake Dr Fort Worth, TX 76133

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 44937 Based on observation, interview, and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services for 2 of 5 residents (Residents #14 and #54) reviewed for tube feeding management. 1. The facility failed to ensure Resident #14 received g-tube stoma site dressing changes and g-tube water flushes according to physician's orders. 2. LVN A and LVN B failed to ensure Resident #54's feeding tube infusion pump rate was correct. These failures could place residents at risk of dehydration, malnutrition, weight loss, and possible infections. Findings included: 1. Record review of Resident #14's face sheet, dated 11/06/24, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #14's quarterly MDS, dated [DATE], reflected she had a BIMS score of 12, which indicated her cognition was intact. She had active diagnoses which included Heart Failure (inability of heart to fill and pump blood), Hypertension (high blood pressure), Renal Insufficiency (kidney failure), Diabetes Mellitus (high blood sugar) Malnutrition (too few nutrients resulting in health problems) The MDS assessment Section GG Functional Abilities reflected Resident #14 required set up or clean up assistance. The MDS assessment Section K - Nutritional approaches reflected Resident #14 had parenteral/IV feeding, feeding tube and was also on a therapeutic diet. (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: 676132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #14's care plan, revised on 08/12/24, reflected Focus: [Resident #14] was dependent on tube feeding for hydration, with potential for complications, side effects. Goal: Will maintain adequate hydration status aeb weight stable, no signs, or symptoms of dehydration through review date. Interventions: Administer tube feeding and water flushes as ordered. See doctor orders for current feeding orders. Monitor weight per protocol or as ordered and record. Notify doctor of significant weight changes. Observe, document, report to doctor as needed aspiration (food entering the respiratory tract instead of the gastrointestinal tract (pathway food entered the body)) signs and symptoms, tube dislodged, infection at tube site, self-extubating, tube dysfunction or malfunction, abnormal lab values, abdominal pain, distention, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, and dehydration. Registered Dietician to evaluate quarterly and as needed. Monitor caloric intake, estimated needs. Make recommendations for changes to tube feeding as needed. Record review of Resident #14's physician's orders revealed: 07/07/23 - Elevate Head of Bed at least 30 degrees while administering formula/water/medications and for at least 30 minutes following administration. 07/11/23 - Clean g/tube site with normal saline, cover with gauze, and secure with tape every day at bedtime 06:00PM-06:00AM. 05/20/24 - Flush Gastrostomy Tube with 200 cc of water every 4 hours 08:00, 12:00, 4:00, 8:00, 12:00, 04:00. 10/30/24 - Diet: Low Calorie Sweetener (LCS), Regular texture, thin liquids continuous - as needed. Record review of Resident #14's MAR and TAR reflected Resident #14 was provided treatment and care to her g-tube site on 11/05/24. Record review of Resident #14's progress note dated 08/07/24 reflected: Tube Feeder Aug weight 186 (BMI 31.9, obese), stable without sig change and usual body weight 180's. Continues on a Regular LCS, thin diet with great app/po, 75% most meals, feeding self. Known to order outside food and snacks/soda which contributes to weight status but appears stable at this time. Diet remains appropriate related Blood Sugar levels and diagnosis of Diabetes, continues on insulin for Blood Sugar control. Fluid intake is encouraged to meet hydration needs, aid with bowels, history UTI and recurrent hypernatremia [high concentration of sodium in the blood]. Has PEG in place but for hydration only (no nutrition) with H2O flush 200ml Q4hr (1200ml fluid); PEG will not be removed as deemed necessary for hydration needs. Observation and interview on 11/04/24 at 11:52 AM revealed Resident #14 sitting in the dining area. Resident #14 stated she was doing well. Resident #14 stated she had a g-tube; however, she ate a regular tray at every meal. Resident #14 was observed to complete her full meal without complications. After her lunch, Resident #14 stated she still had the g-tube but did not use it for eating. Resident #14 pulled her up her shirt to expose her g-tube site. She stated she received water flushes only through the g-tube. When asked how often staff checked her g-tube site and when were the water flushes provided, Resident #14 responded, whenever they do it. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with LVN C on 11/06/24 at 2:00 PM revealed Resident #14's g-tube stoma (an opening in the abdominal that connects the bowel to the outside of the body) had a dressing in place dated 11/04/24. LVN C was asked to observe the date on the bandage, and she stated it was dated 11/04/24. LVN C stated the stoma should have been cleaned and redressed on the night shift. LVN C stated the observation was her first-time flushing water with Resident #14 today (11/06/24). LVN C stated she was aware Resident #14 had several flushes during the day; however, Resident #14 would often refuse, so she had not attempted complete the flush. LVN C she stated she was not aware Resident #14's site had not been cleaned on 11/05/24 night shift. Further observation revealed LVN C she administered air to check for placement, next she stated she was not going to check for residual since Resident #14 did not receive feedings via the g-tube. LVN C did not check for residual. LVN C then administered 200 cc of water with the use of a syringe that she assisted by plunging. When asked if she was going to clean Resident #14's g-tube site, she shrugged her shoulders and left the room. According to LVN C, she was aware that g-tube sites were supposed to be cleaned daily by the nurses on night shift. She stated not checking and cleaning the g-tubes placed residents at risk of infection. LVN C stated not completing the required amount of water flushes would place Resident #14 at risk of dehydration. Interview on 11/06/24 at 2:33 PM with the ADON revealed she was not aware Resident #14's g-tube stoma had not been cared for. The ADON stated she was not aware LVN C had not completed Resident #14's water flushes at 8:00 AM or 12:00 PM. The ADON stated it was her expectation that Resident #14 and all residents with g-tubes have care to be done daily on the 6:00 PM-6:00 AM shift and according to physician's orders. The ADON stated Resident #14's g-tube was still in place and being utilized for hydration. She stated it was the nurse's responsibility to follow physician's orders. The ADON stated if the residents g-tubes were not being cared for it could lead to an infection. The ADON stated she was responsible to ensure nurses were completing their tasks in making sure resident g-tubes were being cared for, and nurses were following physician's orders. ADON stated the nurse that should have completed care on 11/04/24 was an agency staff, and she was not full time staff at the facility. 2. Record review of Resident #54's undated Face Sheet reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included stroke affecting the right side of her body; her ability to swallow requiring her nutrition be provided via a feeding tube in the stomach; and affecting her speech. Record review of Resident #54's quarterly MDS, dated [DATE], reflected her BIMS score was not calculated due to her medical condition. Her Functional Status assessment indicated she was totally dependent on staff for all of her ADL needs. Record review of Resident #54's care plan, dated 07/11/24, reflected she required a feeding tube with Jevity 1.5 to run at 60 cc/hr. Resident #54 also had expressive aphasia meaning she was unable to speak but answered questions by nodding yes or no, and using communication boards. Observation on 11/04/24 at 10:39 AM revealed Resident #54's feeding pump was infusing at 50 cc/hr, while the bottle of Jevity 1.5 was labled with an infusion rate of 60 cc/hr. The bottle had been hung on 11/04 at 4:20 AM. Observations on 11/04/24 at 11:30 AM and 3:30 PM revealed Resident #54's feeding pump rate was infusing at 50 cc/hr. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Trail Lake Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 7100 Trail Lake Dr, Fort Worth, TX 76133	

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 11/05/24 at 7:07 AM and 10:50 AM revealed Resident #54's feeding pump continued to infuse at 50 cc/hr. The Jevity bottle was labeled as being hung on 11/05, no time noted, with a rate of 60 cc/hr. Interview on 11/05/24 at 10:55 AM with LVN B revealed Resident #54's physician order was for the Jevity to infuse at 60 cc/hr. She stated night shift hung the bottles, and she did not know why the pump was set for 50 cc/hr. LVN B stated she had re-started the pump earlier in the morning after it had been paused for morning care. LVN B stated she did not check the rate before pushing Restart on the pump. She stated the Restart button resumed the pump at the previous settings. She stated she was unaware the rate had been incorrect for over 24-hours. She stated the risk of the resident not receiving the correct amount of enteral feedings was weight loss and malnutrition. Interview on 11/05/24 at 11:15 AM with the ADON revealed she had been made aware of Resident #54's feeding pump infusing at the wrong rate. She stated LVN A had hung the bottle on the morning of 11/04/24, and an agency nurse had hung the bottle on 11/05/24. The ADON stated the risk of the resident not receiving the correct amount of nutrition could be malnutrition and weight loss. Observation on 11/05/24 at 12:10 PM of Resident #54 being weighed via a lift device reflected a 1.56% weight loss when compared to her weight on 10/05/24. Interview on 11/05/24 at 1:35 PM with LVN A revealed she had set the pump at whatever rate was ordered. She stated someone must have changed the rate after that. LVN A stated she could not speak to what happened after her shift. Record review of the facility's Enteral Nutrition policy, revised November 2018, reflected: .11. The nurse confirms that orders for enteral nutrition are complete. Complete order include: .e. Volume and rate of administration. .g. instructions for flushing (solution, volume, frequency, timing and 24-hour volume)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 48236 Based on observation, interview, and record review, the facility failed to ensure the menu was followed for one of one lunch meals observed. The facility failed to ensure residents on mechanical soft diets were served soft chicken fried steak they were served soft chicken instead, residents on pureed diets were served pureed chicken instead of pureed chicken fried steak on 11/05/24 as specified by the menu for the lunch meal. This failure could place residents at risk of weight loss, altered nutritional status and diminished quality of life. Findings included: Record review of the August 2024 resident council meeting minutes reflected: .Food that is on menu is not what is being prepared. Record review of the facility's menu on 11/05/24 reflected the planned lunch consisted of chicken fried steak, cream gravy, mashed potatoes, squash medley, dinner roll, frosted cake, beverage of choice, water. Observation on 11/05/24 at 11:30 AM revealed [NAME] D taking temperatures of food items prior to serving, which included mechanical soft and pureed chicken. There was no mechanical soft or pureed chicken fried steak on the steamtable for the lunch service. Interview on 11/05/24 at 11:35 AM with [NAME] D revealed she prepared diced chicken for residents on mechanical soft and pureed diets. When asked why she prepared the chicken, she stated it was an alternate option. When asked where the chicken fried steak was that was going to be served to residents with mechanical soft and pureed diets, she stated she was going to serve them chicken. [NAME] D was asked to provide the survey team with sample trays for each regular, mechanical, and pureed diets. Observation and interview on 11/05/24 at 12:48 PM with [NAME] D revealed a test tray for regular texture diet to include chicken fried steak with cream gravy, mashed potatoes, squash and a pureed texture diet tray of chicken, squash, and mashed potatoes for three surveyors. [NAME] D was asked why the pureed textured tray included chicken and not chicken fried steak. [NAME] D stated she used the diced chicken because it gave a better texture than the chicken fried steak would when pureed. [NAME] D stated she could not give an account why she did not puree the chicken fried steak, other than it would be hard to puree because of the crust on the chicken fried steak. [NAME] D further stated she provided residents on mechanical soft diets with the same diced chicken instead of chicken fried steak because of the texture, she stated it was easier to break down the chicken because it did not have crust on it like the chicken fried stead did. Observation of the chicken fried steak revealed the breading was very thin and could be cut with a fork. [NAME] D stated she was responsible for ensuring all resident were fed based upon the menu. [NAME] D stated she did not see anything wrong with preparing the chicken because it would give them a smoother texture. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/05/24 01:14 PM with the Registered Dietitian revealed she had not had a chance to test the lunch trays today (11/05/24); however, she was informed by the Administrator there was a concern with food items. She stated the cooks were responsible for ensuring the same meal was provided to all residents regardless of the textures. She stated the [NAME] followed the menu by making the chicken fried steak, potatoes, and the squash. She stated [NAME] D did not know chicken fried steak was not chicken, and [NAME] D thought they were the same meat. She stated [NAME] D thought the only difference between the two was that one was fried. The Registered Dietitian stated [NAME] D thought it would be difficult to puree chicken fried steak because it had crust on it. She stated [NAME] D placed residents at risk of not getting served the same food options. Interview on 11/05/24 at 1:34 PM with the Administrator revealed residents should receive what the menu reflected for that day. The Administrator said it was the residents' right to receive what was on the menu, and what they were expecting to eat. The Administrator stated it was the responsibility of the cooks and the Dietary Manager to ensure each resident was provided what was on the menu. Interview on 11/05/24 with the Dietary Manager was unsuccessful, she was on leave of duty due to surgery. Record review of the facility's current, undated Standardized Recipes policy reflected: Standardized recipes shall be developed and used in the preparation of foods. 1. Only tested , standardized recipes will be used to prepare foods. 2. Standardized recipes will be adjusted to the number of portions required for a meal. 3. The food services manager will maintain the recipe file and make it available to food services staff, as necessary. 4. Recipes are periodically reviewed for revisions and updating.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 44937 Based on observation, interview, and record review, the facility failed to ensure the facility provided food that was palatable, for one of one observed meal reviewed for dietary services. The facility failed to serve food that had a palatable flavor during the lunch meal on 11/05/24. This failure could affect residents by placing them at risk of weight loss, altered nutritional status, and a diminished quality of life. Findings included: Interview on 11/04/24 at 10:25 PM with Resident #52 revealed a lot of the times he did not eat the food provided by the facility because it did not taste good. He stated he would decline the meal tray and would ask staff to order take out or prepare food he had in his room. Interview on 11/04/24 at 10:54 AM with Resident #18 revealed the food was cold by the time she received her tray during mealtimes. Interview on 11/04/24 at 12:15 PM with Resident #33 revealed he did not care to eat the food provided by the facility. He stated the food in the facility did not have any flavor or taste, and he preferred not to eat it. Interview on 11/04/24 at 12:18 PM with Resident #9 revealed the food was not consistent with how it would taste. She stated sometimes the food would taste good and other times it would not. Interviews during the confidential resident group interview on 11/04/24 at 1:45 PM with seven alert and oriented residents revealed food was served cold when eating both on the halls and in the dining room. It was also mentioned that food was not tasty and did not have any flavor. Residents stated they had mentioned their concerns in prior resident council meetings; however, they had not seen a change. Interview on 11/04/24 at 2:12 PM with Resident #13 revealed a lot of the time she only ate foods from the alternate menu because she did not like the food provided by the facility. Record review of the facility's menu on 11/05/24 reflected the planned lunch consisted of chicken fried steak, cream gravy, mashed potatoes, squash medley, dinner roll, frosted cake, beverage of choice, and water. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with [NAME] D on 11/05/24 at 12:48 PM revealed the test tray for the regular diets consisted of chicken fried steak with cream gravy, mashed potatoes, squash, and the test tray for the pureed diets consisted of chicken, squash and mashed potatoes. The food temperature of the test trays revealed the food was slightly warm. The squash and mashed potatoes on the regular tray was bland and lacked flavor. The chicken, mashed potatoes, and the squash on the pureed tray also was bland and lacked flavor. [NAME] D stated she agreed the food was bland and lacked flavor. She stated the reason was due to the facility not cooking with salt. [NAME] D stated she followed the menu by adding butter to mashed potatoes, but she stated she could not taste the butter. [NAME] D stated she was responsible for the taste and presentation of the food. [NAME] D stated if the food lacked flavor, it could cause people not to want to eat and cause weight loss. [NAME] D stated she had not had any complaints of food being bland and lacking flavor. Interview on 11/05/24 01:14 PM with the Registered Dietitian revealed she had not had a chance to evaluate the lunch trays today (11/05/24), but she had been informed by the Administrator there was concern with food items. She stated the [NAME] were responsible for ensuring the food provided to residents was enticing and flavorful. She stated [NAME] D followed the menu for the potatoes by using water, butter, and the instant potatoes. She stated she did see seasoning in the squash but could not say why the squash lacked flavor. She stated there were ways to add flavor to food items, such as broth and spices when not using salt. She stated they wanted all the residents to enjoy their meals, so they were getting nutrients they needed. Interview on 11/06/24 at 5:31 PM with the Administrator revealed he would like residents to enjoy the food and not have to use supplements. The Administrator stated the cooks and the Dietary Manager were responsible for following the menu, and not doing so would place residents at risk of weight loss, skin integrity, and their overall health. The Administrator stated he was not aware of the resident council meetings having complaints of the food, however he wanted everyone in the facility to enjoy the food. Record review of the August 2024 resident council meeting minutes reflected: Corporate rejects food and residents are not pleased with meals. Food that is on menu is not what is being prepared. Record review of the September 2024 resident council meeting minutes reflected: Temperature of food, leaves food cart waiting food gets cold. Record review of the October 2024 resident council meeting minutes reflected: will discuss in next resident council meeting. Record review of grievances from August 2024- October 2024 did not include mention food service or menu options. Record review of the facility's current, undated Food and Nutrition Services policy reflected: .Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs., taking into consideration the preferences of each resident. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature. a. If an incorrect meal is provided to a resident, or a meal does not appear palatable, nursing staff will report it to the food service manager so that a new food tray can be issued. b. Foods that are left without a source of heat (for hot foods) or refrigeration (for cold foods) longer than 2 hours will be discarded.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview, and record review 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 of 6 residents (Residents #14 and #33) observed for infection control. 1. LVN C failed to adhere to enhanced barrier precautions by failing to put on a gown prior to flushing Resident #14's g-tube with water. 2. CNA E failed to adhere to enhanced barrier precautions by failing to put on a gown prior to emptying Resident #33's colostomy bag. The failure could place residents at risk for the development of infections which could cause illness or hospitalization . Findings included: 1. Record review of Resident #14's face sheet, dated 11/06/24, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #14's quarterly MDS, dated [DATE], reflected she had a BIMS score of 12, which indicated her cognition was intact. She had active diagnoses which included Heart Failure (inability of heart to fill and pump blood), Hypertension (high blood pressure), Renal Insufficiency (kidney failure), Diabetes Mellitus (high blood sugar) Malnutrition (too few nutrients resulting in health problems) The MDS assessment Section GG Functional Abilities reflected Resident #14 required set up or clean up assistance. The MDS assessment Section K - Nutritional approaches reflected Resident #14 had parenteral/IV feeding, feeding tube and was also on a therapeutic diet. Record review of Resident #14's care plan, revised on 08/12/24, reflected: Focus: Resident #14 was dependent on tube feeding for hydration, with potential for complications, side effects. Goal: Will maintain adequate hydration status aeb weight stable, no signs or symptoms of dehydration through review date. Interventions: Administer tube feeding and water flushes as ordered. See doctor orders for current feeding orders. Monitor weight per protocol or as ordered and record. Notify doctor of significant weight changes. Observe, document, report to doctor as needed aspiration (food entering the respiratory tract instead of the gastrointestinal tract (pathway food entered the body)) signs and symptoms, tube dislodged, infection at tube site, self-extubating, tube dysfunction or malfunction, abnormal lab values, abdominal pain, distention, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, and dehydration. Registered Dietician to evaluate quarterly and as needed. Monitor caloric intake, estimated needs. Make recommendations for changes to tube feeding as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 11/06/24 at 2:00 PM revealed Resident #14 had an enhanced barrier precaution sign at her door, with a bin of PPE. Observation of Resident #14's g-tube stoma (an opening in the abdominal that connects the bowel to the outside of the body) and water flush with LVN C revealed she completed hand hygiene and put on gloves. Without wearing a gown, LVN C flushed Resident #14's g-tube with water. LVN C was asked about the enhanced barrier precaution sign outside Resident #14's door, and she stated when providing care or the water flush for Resident #14, she should have worn gloves and a gown. LVN C stated not doing so placed Resident #14 at risk for spread of infection. 2. Record review of Resident #33's face sheet, dated 11/06/24, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #33's quarterly MDS, dated [DATE], reflected she had a BIMS score of 9, which indicated his cognition was moderately impaired. The MDS reflected Resident #33 was dependent on staff for toileting. Section H Bowel and Bladder indicated he had an Ostomy. His active diagnoses included Hypertension (high blood pressure), End Stage Renal Disease, Diabetes Mellitus (high blood sugar) muscle weakness, lack of coordination. His functional abilities included he required assistance with toileting, shower/bathing and lower body dressing. Record review of Resident #33's care plan, revised on 08/12/24, reflected: Problem: Infection -There is risk for developing and/or spreading infection related to my medical condition. Goal: Enhanced Barrier Precautions will reduce risk of the spread of organisms. Intervention: Utilize enhanced barrier precautions as ordered Every Shift by disciplines: Activities, Administration, CNA, Dietary, Hospice, Housekeeping, Nurse Practitioner, Nursing, Physician A ssistant, Physician, psych, Social Services, Therapy. Problem: Potential for complications, altered body image, knowledge deficit related to colostomy status. Goal: Will remain free from infection or other complications related to colostomy through review date. Intervention: Empty drainage bag as needed. Replace per protocol. Observation and interview on 11/04/24 at 12:15 PM revealed there was an enhanced barrier precaution sign on Resident #33's door, due to the resident having a colostomy. Resident #33 stated staff assisted with emptying the colostomy bag. Observation revealed Resident #33 was lying on his back in bed, a clear bag was underneath his colostomy bag at the bedside. The resident's shirt was lifted at his stomach revealing the colostomy bag contents. Observation and interview on 11/04/24 at 12:21 PM revealed a bin with drawers to the left of Resident #33's door. Inside the drawers was PPE, which included surgical gowns and gloves. Observation of Resident #33's door revealed a sign which indicated to use PPE when performing care prior to entering the room. CNA E entered Resident #33's room with items in hand to empty the resident's colostomy bag. CNA E washed his hands and put on a pair of gloves. Without wearing a gown, CNA E emptied Resident #33's colostomy bag. CNA E stated he was not aware he should also wear a gown when providing care or emptying Resident #33's colostomy bag. CNA E stated he had been trained on enhanced barrier precautions; however, he was not thinking about including the gown during this task. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER: Trail Lake Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 7100 Trail Lake Dr Fort Worth, TX 76133	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/04/24 at 1:00 PM with LVN F revealed Resident #33 was on enhanced barrier precautions due to him having a colostomy. LVN F stated signs were posted at the door which instructed staff to wear PPE including gloves and a gown when providing care to the resident. LVN F stated CNA E was the aide working with Resident #33, and he was responsible for emptying the resident's colostomy bag. LVN F stated she expected CNA E to wear gloves and a gown when emptying the bag and not doing so placed Resident #33 at risk for the spread of infection and illness. Interview on 11/06/24 at 2:43 PM with the ADON revealed there were signs posted along the hall that indicated which residents were on enhanced barrier protection. The ADON stated any resident that required tube feeding, had wounds, or openings to their skin would require all staff especially nurses and aides to use PPE when providing care. The ADON stated not wearing PPE when providing care would place residents at risk of infections. Record review of the facility's Enhanced Barrier Precautions policy, dated March 2024, reflected: Enhanced barrier precautions are utilized to reduce the transmission of multi-drug resistant organisms to residents. Enhanced barrier precautions are used as an infection prevention and control intervention to reduce the transmission of multi-drug resistant organisms to residents. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: 1. dressing; 2. bathing/showering; 3. transferring; 4. providing hygiene; 5. changing linens; 6. changing briefs or assisting with toileting; 7. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and 8. wound care (any skin opening requiring a dressing). Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER Trail Lake Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 7100 Trail Lake Dr Fort Worth, TX 76133	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Wounds generally include chronic wounds (i.e., pressure ulcers, diabetic foot ulcers, venous stasis ulcers, and unhealed surgical wounds), not shorter-lasting wounds like skin breaks or skin tears. Indwelling medical devices include central lines, urinary catheters, feeding tubes and tracheostomies. Peripheral IV catheters are not considered an indwelling medical device for purposes of EBPs