STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676237	A. Building B. Wing	04/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Belmont at Twin Creeks	999 Raintree Circle Allen, TX 75013

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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 0584 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26269 Based on observation, interview and record review the facility failed to provide a safe, clean, and comfortable environment for 2 of 7 (Resident #4 and #5) residents reviewed for resident rights. The facility failed to ensure Resident #4's room, which shared a bathroom with Resident #5's room, was clean and free of urine odors. This failure could place residents at risk of living in an unsanitary, unclean environment which could diminish their quality of life. Findings included: Record review of Resident #4's Face Sheet dated 04/12/24 indicated the [AGE] year-old female was admitted to the facility on [DATE] with diagnoses which included chronic pain, muscle weakness, tibia fracture, age related cognitive decline, adjustment disorder with mixed anxiety and depressed mood. Record review of Resident #4's quarterly MDS dated [DATE] indicated the resident was moderately cognitively impaired with a BIMS score of 8 (a score of 8-12 indicated moderate cognitive impairment). Her diagnoses included coronary artery disease, hypertension, and insomnia. Resident #4 received an antidepressant. The resident had no behaviors and no rejection of care. Resident #4 was continent of bowel and occasionally incontinent of urine. The resident did not receive a urinary toileting program. Record review of Resident #4's Care Plan, effective from 11/10/20 to the present, dated 04/12/24 indicated the resident rejected care. The resident gets upset when staff enters her room to check on her. The resident refused to allow the facility to wash her soiled laundry. The resident refused assistance to the restroom and refused to allow bed linen changes; the goal was to minimize the resident's resistance care over the next 90 days. The interventions included, to talk to the resident/family about her reasons for refusal of care and the potential risk, when care is refused remind the resident of the potential risk. Coax but do not force compliance. The care plan did not address the resident's physical environment. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's Psychological Progress Note dated 012/12/23 indicated, the resident yelled very angrily for the therapist to go away because she was using the bathroom. The therapist returned later, and the resident was calm. The resident believed she did not need to reside in the facility because she could take care of herself. Record review of Resident #4's Psychological Progress Note dated 01/02/24 indicated, the Therapist also noticed incontinence and strong odor of urine in her room. The resident insisted she did not need to wear briefs, only needed cloth underwear. Record review of Resident #4's Psychological Progress Note dated 01/17/24 indicated self-care and hygiene was discussed because the resident did not accept her incontinence and would not wear briefs. Record review of Resident #4's Clinical Note dated 03/27/24 at 10:34 AM indicated the SW sent a referral for the resident to be placed in a facility with a memory care unit. Record review of Resident #4's Clinical Note dated 03/27/24 at 11:52 AM indicated the SW documented she was notified around 9:00 AM the resident continued to urinate on items and there was a strong odor of urine coming out of the resident's room. There was no documentation of any interventions or attempts to encourage the resident to allow care. Record review of Resident #4's Clinical Note dated 03/27/24 at 12:50 PM indicated the SW documented she was notified around 12:50 PM the resident told housekeeping to get the fuck out of her room and declined housekeeping. There was no documentation of any interventions or attempts to encourage the resident to allow the housekeeping services. Record review of Resident #4's Clinical Note dated 04/01/24 at 5:31 PM indicated the SW contacted other facilities to see if they would accept the resident. Record review of Resident #4's Clinical Note dated 04/03/24 the SW contacted a facility with a memory care unit to see if they would accept the resident. Record review of Resident #4's Clinical Note dated 04/10/24 at 9:42 AM the nurse documented the resident was in her room in bed. The resident refused care and was noted lying in soiled urine. The resident refused to allow staff to assist her with her personal hygiene and linen change. The resident was educated on the importance of personal hygiene and compliance with care. The resident continued to refuse all care from staff. There was no documentation regarding further attempts or interventions to encourage the resident to allow care. An observation on 04/10/24 at 4:20 PM, over six hours from the resident's documented refusal of care at 9:42 AM, revealed a strong smell of urine on Resident #4's Hall. The eight residents', who resided on Resident #4's hall, doors were closed, and the urine odor permeated the entire hall. In an interview on 04/10/24 at 4:30 PM ADON B stated Resident #4 had been refusing care for several days and her bed sheets needed to be changed because they were saturated with urine; he stated that was why the hall, even with Resident #4's door closed, smelled so strongly of urine. He stated a CNA was in Resident #4's room providing care, but the resident was upset care was being provided and did not want staff in her room. He stated Resident #4's refusal of care had been an ongoing issue. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 04/10/24 at 4:35 PM Resident #4's door was closed, the investigator knocked on the door and an unknown CNA answered the door and stated she was providing care to Resident #4. Record review of Resident #4's Clinical Note dated 04/10/24 at 5:15 PM the Administrator documented the Housekeeping Supervisor went to speak to the resident on 04/10/24 at 4:43 PM about cleaning her room and carpet, but after multiple attempts the resident continued to refuse to allow her room to be cleaned. The facility was waiting to hear back about placement for Resident #4 at another facility. In an interview with the DON at 04/12/24 at 9:46 AM the Investigator asked the DON what the facility was doing to address Resident #4's refusal of care and the urine odor. The DON stated the facility was trying to discharge the resident to another facility because the resident was non-complaint with care. The DON stated the resident refused to bathe, urinated in the room, and refused to allow staff to clean her room. The DON stated staff had been trying since Saturday (04/06/24) to provide care to the resident and clean the resident's room but the resident refused. The DON stated the resident's family member visited the resident and tried to encourage the resident to allow care, but the DON did not feel the resident was appropriate for the facility setting because of the resident's worsening dementia. The DON stated the resident's family member did the resident's laundry. The DON stated the SW was working a lot with the resident. In an interview on 04/12/24 at 12:37 PM the SW stated Resident #4 had a strong smell of urine in her room and to her person even when the resident left her room. The SW stated she was not the one who specifically attempted to intervene when the resident refused care. The SW stated the Housekeeping Supervisor knew the resident better and tried to encourage her to allow the room to be cleaned. The SW stated the facility made referrals for Resident #4 to receive psychiatric services and had spoken to the resident's family member about discharging the resident to a facility with a memory care unit. In an interview on 04/12/24 at 1:03 PM the Housekeeping Supervisor stated Resident #4 had the right to refuse housekeeping services and the resident would often tell the housekeeping staff to get out of her room. He stated the resident did not leave her room very often, but she had gone on trips to the store in the past. He stated when the resident left her room to go to the store or use the phone the housekeeping staff was able to go in and clean the resident's room. He stated housekeeping could not force the resident to leave her room and the resident did not participate in group activities, although the AD invited her to join. He stated a while back one resident, he could not remember which resident, mentioned the hall smelled of urine but housekeeping was able to go in and clean Resident #4's room. He stated the situation was hard on housekeeping because the hall smelled strongly of urine and the housekeeping staff had to frequently pass by the resident's room and spray a deodorizer. He stated the resident allowed the housekeeping staff into her room earlier today (04/12/24) and housekeeping cleaned the resident's room and shampooed her carpet. In an observation and interview on 04/12/24 at 11:55 AM revealed Resident #4 was in bed, she had items in bags on the floor of the room, the room smelled of urine. She stated she did not want or need assistance from the staff because she was independent. She stated she wanted to move to her own apartment closer to her family member. She reported no issues with her care or treatment in the facility. The resident's bathroom was shared with Resident #5. The door to Resident #5's room, from the shared bathroom, was closed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 04/12/24 at 11:59 AM, a concerned party stated, a while ago during a visit with Resident #4, the room was super messy, smelled strongly of urine, and looked like a bomb had gone off in the room. The concerned party stated maybe the facility could do a little more to try to keep Resident #4's room cleaner and tidier. Record review of Resident #5's Face Sheet dated 04/12/24 indicated the [AGE] year-old female resident was admitted to the facility on [DATE] with diagnoses which included an arm fracture. Record review of Resident #5's quarterly MDS dated indicated the resident was cognitively intact with a BIMS score of 13 (a score of 13-15 indicated cognitively intact). She was frequently incontinent of urine and always incontinent of bowel. She required partial assistance with toileting and personal hygiene. In an observation and interview on 04/12/24 at 12:00 PM revealed Resident #5 was in her room in bed. The shared bathroom door with Resident #4 was closed. There was no odor of urine in Resident #5's room. Resident #5 stated said she did not use the shared bathroom because she did not get up to go to the bathroom. She stated she requested the door to the bathroom be closed at all times due to the strong smell of urine coming from Resident #4's room and bathroom. She stated Resident #4 refused care, so she understood why the room smelled of urine. She stated the urine smell was sometimes worse than others. She stated a friend visited her and must have smelled the urine odor because the next time her friend visited she brought her an air freshener. In an interview on 04/12/24 at 1:35 PM the Administrator stated she was aware Resident #4 refused care and housekeeping services. She stated Resident #4's refusal of care had increased, and the facility was trying to discharge the resident to a facility with a memory care unit. She stated staff try to encourage the resident to come out of her room so housekeeping can clean the room. She stated the facility has tried to get the resident to participate in group activities and physical therapy to encourage the resident to come out of her room more, but the resident has refused. She stated she did not know of any other interventions used to try to get the resident to come out of her room and allow housekeeping staff to clean the room. Record review of the facility's policy Homelike Environment dated February 2021 indicated residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. The facility staff and management minimize, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. The characteristics included institutional odors.

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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** 38332 Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 (Residents #2 and #8) of 4 residents reviewed for incontinence care. CNA A and CNA B failed to perform hand hygiene during incontinence care for Resident #2 and Resident #8. These failures placed all residents at risk of unintended infections and inadequate treatment. Findings included: Resident #8 Record review of Resident #8's Face Sheet revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. His diagnoses included: hypertension (high blood pressure), dementia, psychotic disturbance, debilitating cardiorespiratory conditions, current urinary tract infection, Parkinson's disease, benign prostatic hyperplasia with lower urinary tract symptoms and suprapubic catheter (an opening in the lower abdomen with a device to drain urine from the bladder.) Record review of Resident #8's comprehensive MDS assessment dated [DATE] revealed a BIMS score of 3 indicating severe cognitive impairment. He was always incontinent of bowel and bladder and totally dependent on staff assistance. Record review of Resident #8's care plan (print date 04/10/24) revealed a self-care deficit, extensive assistance required with bathing, hygiene, dressing and grooming. His interventions included monitor for incontinence. Change pads/briefs as needed, provide hygiene after voiding/bowel movement to prevent skin breakdown. Observation on 04/12/24 at 12:24 AM when entering Resident #8's room CNA A was in the bathroom disposing of a container of urine into the toilet. CNA A said she had completed catheter care on Resident #8 but still needed to change his brief and wipe his buttocks off. CNA C was standing on one side of the bed assisting Resident #8 to lie on his side. CNA A washed hands in bathroom returned to the bedside and applied gloves. CNA A proceeded to clean Resident #8's buttocks area with the wipes and disposed of them in the trash can. When CNA A finished, she removed her gloves and applied new gloves without washing her hands or using hand sanitizer. CNA A and CNA C assisted Resident #8 with repositioning with pillows and his blanket was pulled back up. An interview on 04/12/24 at 12:28 AM with CNA C said this was her second day working at the facility and was being oriented by CNA A. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 04/12/24 at 12:28 AM CNA A said she had incontinence care/peri care training and infection control/hand hygiene training about 2 months ago. She said she was trained to wash her hands or use hand sanitizer with glove changes. She said she had forgotten to wash her hands or use hand sanitizer after removing her gloves. CNA A said if peri care was not done properly it increases risk of infection such as a urinary tract infection. Resident #2 Record review of Resident #2's Face Sheet revealed an [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Her diagnoses included: gastro-esophageal reflux disease (liquid from stomach refluxes into esophagitis), gastrointestinal hemorrhage (gastrointestinal bleed), major depressive disorder, panic disorder, anxiety disorder and hypertension (high blood pressure). Record review of Resident #2's of last quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 indicating intact cognition. The MDS identified Resident #2 was always incontinent of urine and frequently incontinent of bowel and needed moderate assistance with toileting and personal hygiene. Record review of Resident #2's care plan (print date 04/10/24) revealed a self-care deficit with interventions to provide assistance with self-care as needed. She was always incontinent (bowel and bladder) with interventions included check for incontinence; change if wet/soiled, clean skin with mild soap and water, apply a moisture barrier, check skin for areas of redness and use pads/ briefs to manage incontinence. Observation on 04/12/24 at 12:56 AM revealed CNA A and CNA B entered the room of Resident #2. CNA A and CNA B washed their hands and donned gloves in the resident's bathroom. Resident # 2 was lying on her back in the bed with one CNA standing on each side of the bed. CNA A pulled down the linen on Resident #2. CNA A and CNA B unfastened the brief and turned the resident on her side to remove the soiled brief. CNA B cleaned Resident #2's buttocks then removed her gloves and applied new gloves without washing her hands or using hand sanitizer. CNA B placed a clean brief under the resident. CNA B opened a dresser drawer and pulled out a tube of barrier cream. CNA B applied another pair of gloves over the other gloves and applied the barrier cream on Resident #2's buttocks. CNA B removed the outer pair of gloves and threw them in the trash can then positioned the resident on her back. CNA B removed a wipe from the container and wiped the perineal area. CNA A continued to use the same gloves to fasten the resident's new brief, reposition the resident in bed and placed her belongings within reach. CNA A did not wash her hands or use hand sanitizer before she pulled up the blanket to cover the resident. An interview on 04/12/24 at 1:05 AM with CNA B revealed she had been in-serviced on incontinence care and hand hygiene a couple of months ago. She said she should have washed her hands or used hand sanitizer when she changed her gloves according to her training on incontinent care. Interview on 04/12/24 at 9:46 AM, the DON said CNA A notified her that she forgot to wash her hands between glove changes during the observation with the surveyor. She expected her nurses and CNAs to wash their hands upon entering and exiting resident rooms and with glove changes. She said she had training with her staff on infection control such as hand washing, incontinence care, and indwelling catheter care. The DON revealed in March 2024 there were 2 residents with positive urine culture for E. coli. She said E. coli in urine was typically from improper wiping. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Handwashing/Hand Hygiene policy revision date of April 2019 reflected in part: .This facility considers hand hygiene the primary means to prevent the spread of infections. 2. All personnel shall follow the handwashing/ hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. .7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: .h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's intact skin; j. After contact with blood or bodily fluids .m. After removing gloves .