

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2024
NAME OF PROVIDER OR SUPPLIER The Belmont at Twin Creeks		STREET ADDRESS, CITY, STATE, ZIP CODE 999 Raintree Circle Allen, TX 75013	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47030</p> <p>Based on observation, interview and record review, the facility failed to ensure all allegations of abuse were reported immediately to the State agency, thoroughly investigated, and residents were protected during investigation for 1 of 5 residents reviewed for abuse and neglect. (Resident #34).</p> <p>The facility failed to report immediately to the State agency when Resident #34 was found alone on the floor in her room.</p> <p>These failures could place residents at risk for not having allegations of abuse investigated.</p> <p>Findings included:</p> <p>Record Review of physician orders dated 3/22/2024 indicated Resident #34 was admitted on [DATE], was [AGE] years old, and her diagnoses included, long term (current) use of anticoagulants; Essential (Primary) hypertension; edema, unspecified; estrogen excess; hyperlipidemia, unspecified means your blood has too many lipids, or fats, such as cholesterol and triglycerides; unspecified asthma, uncomplicated; mononeuropathy, unspecified is damage to a single nerve, usually near the skin or a bone. It can cause pain, numbness, and weakness; hypothyroidism is a disorder of the endocrine system in which the thyroid gland does not produce enough thyroid hormones. unspecified.</p> <p>Record review of the MDS revealed a BIMS score of 9 indicating moderately impaired cognition,</p> <p>Observation and interview on 03/19/24 at 08:52 AM revealed Resident #34 lying in bed with the television on. Resident #34 had multiple bruises on her face. On 03/20/24 at 11:07AM Resident #34 said she fell . Resident #34 consented to having photos taken of her bruises. Pictures were taken of the Resident #34's face front and both sides along with quarter size bruise on left wrist area.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 03/20/24 at 03:26 PM with RN D revealed she was working when Resident#34 fell . RN D revealed Aides had just given Resident #34 her breakfast and Resident #34 was sitting in her wc. RN D revealed the Receptionist walked past Resident #34's room and yelled out for a nurse to come to the room. RN D revealed Resident #34 was laying on the floor on her right-side. RN D revealed blood was coming out of Resident #34's head in small amounts, not streaming. RN D revealed Resident #34 was able to talk and say she fell . RN D indicated Resident #34 could not verbalize how the fall occurred. RN D revealed Resident #34's pants were half on. RN D checked vials, called the attending, and ADON. RN D revealed she cleaned the wound and put on a dressing and applied pressure. The MD gave order to do dressings and neurologic checks every 15 min then 4x every 30 minutes then each shift as the neurologic check form indicates. No x-rays were ordered. RN D said she had the treatment nurse check the wound the same day.</p> <p>Interview on 03/21/24 at 03:36 PM LVN Q revealed most of Resident #34's falls are due to trying to toilet herself. LVN Q revealed the following to help prevent falls: keep door to room open, encourage Resident #34 to call for help-(LVN Q revealed Resident #34 forgets), do every15 minute checks on Resident #34. LVN Q revealed he did not witness the most recent fall for Resident #34. LVN Q revealed as he came on shift, he was given report about Resident #34's fall from the outgoing nurse.</p> <p>Interview on 03/22/24 at 11:25 AM Receptionist revealed while walking down the 300 hall she saw Resident #34 on the floor in her room. The Receptionist revealed from just outside the resident's doorway she saw Resident #34 laying on her right side with the right side of her face with blood on the floor. The Receptionist revealed Resident #34 was not yelling or anything. The Receptionist said she flagged down the nurse and aide to come to the room.</p> <p>Interview on 3/22/24 at 12:00 noon Aide P revealed just prior to the fall Resident #34 was at the nurse's station. Aide P revealed she did not witness Resident #34's fall. Aide P said the Receptionist walked past Resident #34's room and found the resident on the floor. Aide P revealed her, and the nurse went to Resident #34's room where they assisted Resident #34 get into bed. Aide P reported I think there was blood on ground and a little in resident #34's hair. Aide P reported she did not remember if Resident #34 showed or expressed pain. Aide P reported she does not remember what time this occurred.</p> <p>Interview on 3/22/24 at 3:28pm the Administrator reported for falls they do assessments, monitor for pain, injury, notify Attending for orders of x-ray and/or send out to the hospital. The Administrator revealed they would find out what caused the fall. The Administrator revealed if the resident hit their head, they usually would send out depending on the outcome of the neuro checks, and if residents can tell what happened. The Administrator revealed the facility did not report the injury saying it did not meet the criteria for reporting. The Administrator is the Abuse Coordinator.</p> <p>Interview on 3/22/24 at 5pm the Treatment nurse- revealed he called the family members of Resident #34, who separately told him the same thing about the fall. The Treatment nurse revealed Resident #34 said the same as the that the reason for the fall was Resident #34 was bending over to try and pull up her pants and fell . The Treatment nurse stated he believes he documented but a record review reflected no documentation from the treatment nurse.</p> <p>Record Review of the facility's Reportable Incident Protocol Policy reflects the following,</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1) Ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source .</p> <p>4) Report the results of all investigations to the Executive Director or his or her designee and to other officials in accordance with State law, including the State Survey Agency within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>The agency policy goes on to define injuries of unknown source as Any injury should be classified as an injury of unknown source when both of the following conditions are met:</p> <ul style="list-style-type: none"> - The source of injury was not observed by any person, or the source of the injury could not be explained by the patient. <p>AND</p> <ul style="list-style-type: none"> - The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incident of injuries over time. 		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747</p> <p>Resident #95</p> <p>PASARR</p> <p>Resident [NAME] was a [AGE] year-old female, admitted to the facility on [DATE], with diagnoses including alkalosis, chronic obstructive pulmonary disease, bipolar disorder, anxiety disorder, etc.</p> <p>03/19/24 10:35AM - Observation of Resident [NAME] revealed she was clean, well-groomed, and appropriately dressed. She was free from any odors. There were no visible marks or bruises noted on her person. Resident [NAME] was alert and oriented; she was also visibly distressed and crying out. She stated facility staff treated her exceptionally well - she stated she had the best nurses and aides in the world. She had no concerns regarding the facility or the care received. However, she described trauma she had recently sustained including almost dying due to illness and her daughter recently dying. She appeared to be very upset and grief-stricken throughout the duration of the interview.</p> <p>03/19/24 - 03/22/24 - Additional observations of Resident [NAME] throughout the course of the survey process revealed she was consistently clean, well-groomed, and appropriately dressed. She was free from any odors. There were no visible marks or bruises noted on her person. The surveyor did not note any additional instances in which she was displaying obvious signs or symptoms of distress.</p> <p>03/21/24 3:03PM - During an interview with Faye [NAME] (MDS Coordinator), she stated Resident [NAME]' PASRR Level I was completed at the hospital and indicated she did not have a mental illness, and therefore did not qualify for a PASRR Level II. MDS Coordinator [NAME] stated upon a resident's admission to the facility, she verified a PASRR Level I had been completed and reviewed the resident's diagnoses to ensure they were appropriately captured on the PASRR Level I. She stated when she checked Resident [NAME]' PASRR Level I and medical history, her diagnoses including bipolar disorder and anxiety disorder were not in her medical history. She stated because of these diagnoses, she should have received a PASRR Level II evaluation. MDS Coordinator [NAME] stated she did not believe there were any risk factors, such as a potential lack of services, with Resident [NAME] not receiving a PASRR Level II evaluation.</p> <p>03/21/24 3:29PM - The surveyor attempted to contact Oluchi Ozoagu (RN/Charge Nurse, the staff member who initiated Resident [NAME]' Baseline Care Plan). The surveyor left a voice message requesting a return telephone call.</p> <p>Review of Resident [NAME]' PASRR Level I, dated 02/15/24, reflected there was no evidence or indicators that she had a mental illness.</p> <p>Review of Resident [NAME]' Baseline Care Plan, dated 03/21/24 but initiated on 02/14/24 by Oluchi Ozoagu (RN/Charge Nurse) revealed no areas of the Baseline Care Plan had been completed.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747</p> <p>Based on observation, interview, and record review, the facility failed to ensure individuals with mental disorders were evaluated and received care and services in the most integrated setting appropriate to their needs for 1 of 3 residents (Resident #95) reviewed for PASRR Level I screenings.</p> <p>The facility did not correctly identify Resident #95 as having a mental illness and did not complete a new PASRR Level I Screening.</p> <p>This failure placed residents at risk of not receiving adequate services or care related to mental illnesses.</p> <p>Findings included:</p> <p>Review of Resident #95's Face Sheet, dated 03/22/24, reflected she was a [AGE] year-old female who admitted to the facility on [DATE], with diagnoses including bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>Review of Resident #95's MDS Assessment, dated 02/21/24, also reflected she had diagnoses including depression (other than bipolar) and manic depression (bipolar disease).</p> <p>Review of Resident #95's PASRR Level I Screening, dated 02/15/24, reflected there was no evidence that Resident #95 had indicators of a mental illness.</p> <p>Observation of Resident #95 on 03/19/24 at 10:35AM revealed she was clean, well-groomed, and appropriately dressed. She was free from any odors. There were no visible marks or bruises noted on her person. Resident #95 was alert and oriented; she was also visibly distressed and crying out.</p> <p>During an interview with Resident #95 on 03/19/24 at 10:35AM, she stated facility staff treated her exceptionally well and reported she felt as though she had the best nurses and aides in the world. She had no concerns regarding the facility or the care received; however, she described trauma she had recently sustained including almost dying due to illness (prior to her admission to the facility) and her immediate family member recently dying without a known cause. She appeared to be very upset and grief-stricken throughout the duration of the interview.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the MDS Coordinator on 03/21/24 at 3:03PM, she stated Resident #95's PASRR Level I was completed at the hospital prior to her admission and indicated she did not have a mental illness; therefore, she did not qualify for a PASRR Level II evaluation. The MDS Coordinator stated upon a resident's admission to the facility, she verified a PASRR Level I screening had been completed and reviewed the resident's diagnoses to ensure they were appropriately captured on the PASRR Level I screening. She stated when she checked Resident #95's PASRR Level I screening and medical history, her diagnoses including bipolar disorder, major depressive disorder, and anxiety disorder had not been uploaded in her medical history. She stated because of these diagnoses, Resident #95 should have received a PASRR Level II evaluation. The MDS Coordinator stated she was not aware of any risk factors present due to Resident #95 not yet receiving a PASRR Level II evaluation.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35747</p> <p>Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 (Resident #95) of 3 residents reviewed for baseline care plans, in that:</p> <p>The facility failed to ensure Resident #95's baseline care plan was completed and included information related to her care needs and status at the time of her admission.</p> <p>This failure could place newly admitted residents at risk of not receiving continuity of care and communication among nursing home staff to ensure their immediate care needs are met.</p> <p>Findings included:</p> <p>Review of Resident #95's Face Sheet, dated 03/22/24, reflected she was a [AGE] year-old female who admitted to the facility on [DATE], with diagnoses including bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>Review of Resident #95's MDS Assessment, dated 02/21/24, also reflected she had diagnoses including depression (other than bipolar) and manic depression (bipolar disease). Resident #95 was identified as needing ADL assistance including bathing and dressing.</p> <p>Review of Resident #95's Baseline Care Plan, dated 02/14/24, reflected no areas of the document had been completed; there was no information regarding Resident #95's status or care needs.</p> <p>During an interview with the Administrator on 03/22/24 at 3:48PM, she stated the expectation was for baseline care plans to be completed upon a resident's admission to the facility, by the nursing staff completing the admission. She stated the risk of a resident's baseline care plan not being completed included staff not knowing how to best care for a resident.</p> <p>The facility's policy regarding baseline care plans was requested from the Administrator on 03/22/24 at 4:57PM but was not provided.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193</p> <p>Based on observation, interviews and record review the facility failed to develop and implement a comprehensive person care plan for each resident that included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs for two of eight residents reviewed for care plans. (Residents #08 and #35).</p> <p>The facility failed to develop and implement person-centered care plans for Residents #08 and #35.</p> <p>This deficient practice placed residents at risk of not having their individualized needs met in a timely manner and communicated to providers and could result in injury and a decline in physical well-being.</p> <p>Findings Included:</p> <p>1. Review of Resident #08's Face Sheet, dated 06/15/23, reflected he was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses including Dementia (a term used to describe a group of symptoms affecting memory, thinking and social abilities), psychotic disturbance(a group of serious illnesses that affect the mind) and anxiety disorder (anxiety disorder includes persistent and excessive anxiety and worry about activities or events) and schizophrenia.</p> <p>Review of Resident #08's Care Plan, with a section dated 06/15/23 reflected,</p> <p>Resident #08 problems included: Parkinson's Disease and is at risk for injury from increased tremors and involuntary muscle movement. Record review of Resident #08 care plan reflected, was took Sinemet . Record review of Resident#08 care plan reflected, goals .no occurrence of injuries . Record review of Resident#08 care plan reflected, interventions included: Give medication as order and monitor labs No documentation of Resident #08 schizophrenia</p> <p>Review of Resident #08 patient medication profile (undated) reflected, Resident# 08 was proscribed Seroquel 25mg tablet for three times a day. Record review of Resident #08 Patient Medication profile reflected; Seroquel medication is used to treat certain mental/mood disorders (such as schizophrenia .)</p> <p>Review of Resident #08 quarterly MDS, dated [DATE], reflected Resident #08 had a BIMS of 03, severe cognitive impaired. Record review of quarterly MDS reflected active diagnosis of psychiatric/mood disorder included Schizophrenia.</p> <p>Interview at 03/22/24 at 2:00 PM with MDS coordinator revealed she overlooked the diagnosis and did not add it to his care plan. The MDS coordinator stated by not adding the Schizophrenia diagnosis could prevent the resident from getting the care he needed. The.MDS coordinator stated her, and the DON are responsible for adding information to care plan.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview at 03/22/24 at 2:15 PM with DON revealed that residents' family member wanted resident to be back on Seroquel because the last hospital visits the doctors put him on that medication. The DON revealed she found pervious documentation that resident was on Seroquel when he was in [state]. Family member signed the consent on 02/29/24 and resident began medication treatment. The DON stated care could be missed by not adding needed information to care plan.</p> <p>2. Record review of Resident #35's face sheet, dated 03/22/24, reflected a [AGE] year-old female, was admitted to the facility on [DATE] with the following diagnoses which included, acute kidney failure (occurs when your kidneys suddenly become unable to filter waste products from your blood), hypertensive (commonly known as high blood pressure), type 2 diabetes mellitus (condition characterized by high blood sugar levels, insulin resistance, and relative lack of insulin), and vitamin deficiency and pain.</p> <p>Record review of Resident #35's Admission MDS, undated, reflected Resident #35 had a BIMS score of 15 reflecting no cognition impaired. Required minimum to maximum assistance with activities of daily living. Resident #35 was taking anticoagulants, hypnotics, opioids, and hypoglycemia (including insulin).</p> <p>Record review of Resident #35's Comprehensive Care Plan revealed the resident did not have a care plan.</p> <p>Observation and interview on 03/19/24 at 12:15 PM, revealed Resident #35 was in the room. Resident #35 was in the room, she was awake and alert. The resident stated she was having a cough and it was getting better.</p> <p>In an interview on 03/21/24 at 11:53 AM with LVN H (ADON), she reviewed the clinical records and then LVN H stated Resident #35 was missing the care plan. LVN H stated she did not complete the Resident #35's care plan because she missed to complete the care plan. LVN H stated she completed the comprehensive care plan of the residents upon admission and at times the MDS personnel will complete the care plan. LVN H stated Resident #35 care plan was to be completed to indicate the resident's care needs. LVN H stated Resident #35 not having a care plan could lead to the staff not meeting the resident's care. LVN H stated she was the only one responsible to make sure the care plans were completed timely.</p> <p>In an interview on 03/22/24 at 10:13 AM with the DON she stated she was responsible to check and make sure the care plan was completed timely. The DON stated she completed random checks to make sure the nurses were completing the care plan correctly, and she had not checked if Resident #35 care plan had been completed. The DON stated the care plan was to be completed to show the resident needs and goals and interventions met.</p> <p>Record review of the facility policy, revised March 2022 titled, Care Plan, Comprehensive Person-Centered reflected, A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, physiological and functional needs is developed and implemented for each resident. A comprehensive person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual, or Significant Change in Status), and not more than 21 days after admission. Tge policy also reflected, .12. The interdisciplinary team reviews and updates the care plan:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>07. B) Describes the services that are to be furnished to attain or maintain the resident's highest practicable . e) reflects currently recognized standards of practice for problem area and conditions .</p> <p>12. C) when the resident has been readmitted to the facility from a hospital stay. D) At least quarterly, in conjunction with the required quarterly MDS assessment .</p> <p>46403</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents who are fed by enteral means receive the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, and metabolic abnormalities for one resident (Resident #51) of 2 residents reviewed for enteral nutrition.</p> <p>LVN E failed to check for residual volume prior to medication administration for Resident #51</p> <p>These failures could affect all residents who receive enteral feeding and place them at risk for metabolic abnormalities, medical complications, or a decline in health due to not following appropriate procedures.</p> <p>Findings included:</p> <p>Review of Resident #51's face sheet, dated 03/22/24, reflected the resident was a [AGE] year-old female who originally admitted to the facility on [DATE]. Her diagnoses included Gastrostomy status (an opening in the stomach at the abdominal wall made surgically to introduce food), hypertension, type 2 diabetes, and chronic kidney disease.</p> <p>Review of Resident #51's annual MDS Assessment, undated, revealed Resident #51's BIMS score of 3 which indicated severe cognitive impaired. Resident # 51 required extensive assistance with activities of daily living with one to two persons assist. Further review revealed Resident #51 had a feeding tube, which she received 51% or more of the total calories.</p> <p>Record review of Resident #51's physician order review dated 02/23/22 reflected an order to, Check tube for proper placement by auscultation of injected air (place a stethoscope on the left side of the abdomen just above the waist) or visual inspection of aspirated stomach contents prior to instilling medication, and/or initiating a feeding. Check every shift . Order Date: 2/23/2022.</p> <p>Observation on 03/19/24 at 07:36 AM, revealed LVN F administering medication to Resident #51 through the feeding tube. LVN F got the following medications ready, levothyroxine 175 mg Aspirin chewable 81 mg, Acidophilus with citrus pectin, Vitamin D3 25 mcg (1000iu), Vitamin C 500 mg, Daily vitamins, Isosorbide 30 mg, Amlodipine Besylate 10 mg, Thiamin vitamin B-1 100 mg, Carvedilol 6.25 mg, Hydralazine HCL 100 mg, Protein supplement 30 cc. Crushed the medications separately in different medication cups and mixed with 10 cc of water. LVN F then checked for placement, staff did not check for residual. LVN F then administered medications and flushed in between medications and after medication administration.</p> <p>In an interview on 03/19/24 at 08:28 AM with LVN F she stated she was supposed to check for residual, but she forgot. She stated she was supposed to check for residual to check if the resident was not being overfed and digestion was okay. LVN F stated if Resident #51 had a lot of fluids in the stomach could lead to aspiration (happens when food, liquid, or other material enters a person's airway and eventually the lungs by accident).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Belmont at Twin Creeks		STREET ADDRESS, CITY, STATE, ZIP CODE 999 Raintree Circle Allen, TX 75013	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 03/22/24 at 10:25 AM with the DON she stated LVN F was supposed to check for residual before medication administration, to make sure the feeding tube was at the right place and the amount in the stomach. The DON stated if the stomach was too full it could lead to aspiration. The DON stated she was responsible to check and make sure the medication administration was completed per the orders and correctly. The DON stated the facility had completed feeding tube medication administration check off in February, and LVN F was among the staff who had the check off. Reviewed the in-service and revealed LVN F completed the check off.</p> <p>Record review of the facility policy revised 2018, titled Administering Medication through an Enteral Tube reflected, .6. Verify placement of the feeding tube: a. If you suspect and improper tube positioning, do not minister feeding or medication. Notify the charge nurse or Physician. The policy did not address checking for residual.</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193</p> <p>Based on interview and record review the facility failed to ensure parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders for 1 of 2 (Resident #250) residents reviewed for parenteral fluids.</p> <p>The facility did not ensure Resident #250's central line (a tube that is inserted into a large vein in the neck, chest, groin, or arm to give fluids, blood, medications, or to do medical tests quickly) dressing was changed per the physician's order.</p> <p>This failure could place residents at risk for receiving care that is not safe and meets professional care standards.</p> <p>Findings Included:</p> <p>Record review of the face sheet dated 03/22/24 indicated Resident #250 was a [AGE] year-old female who discharged from the facility on 02/12/24. She was admitted to the facility on [DATE] with diagnoses including infection of the humerus, hypertensive heart disease (is a condition where long-term high blood pressure (hypertension) puts extra strain on the heart, causing it to work harder than normal), pain, Type 2 diabetes (condition that happens because of a problem in the way the body regulates and uses sugar as a fuel).</p> <p>Record review of the admission MDS undated indicated Resident #250 usually understood others and was usually understood by others. The MDS indicated Resident #250 had a BIMS of 4, indicating a severe cognitive impaired. The MDS indicated Resident #250 was receiving antibiotics through her central line.</p> <p>Record review of the care plan dated on 01/18/24 revealed there was no care plan for the central line.</p> <p>Record review of the physician orders dated 03/22/24 indicated Resident #250 had an order to change the central line dressing every (left blank) days starting 01/19/24.</p> <p>Record review of the electronic medication administration record (EMAR) dated 03/20/24 for the month of January indicated Resident #250's central line dressing was changed on 01/19/24 and scheduled to be changed on 01/26/24 but the central line dressing was not changed. Review of the EMAR dated 03/20/24 for the month of February revealed the central line dressing was changed on 02/02/24.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 03/22/24 at 11:30 a.m. with RN D, she stated Resident #250 had a central line to the right upper arm, and the dressing on the central line was to be changed weekly per the facility policy. RN D stated, Resident #250's responsible party had complained of the dressing not being changed. RN D stated it was on a Friday (could not remember the date) when the responsible party had complained and she was not able to change the dressing so, RD D informed the afternoon charge nurse (who no longer worked in the facility) if she could change the dressing. RN D did not work on that weekend, so when she worked the following Monday (did not remember the date), she noticed the central line dressing had not been changed, then she changed the dressing. RN D stated the dressing was not changed after 7 days per facility policy. RN D stated she did not remember if there were orders in for the dressing change to be completed, and she did not remember the nurse who was responsible for changing the central line dressing. RN D stated she only changed the central line dressing once while the resident was in the facility. RN D stated central line dressing was to be completed every 7 days per facility policy to prevent infection of the central line.</p> <p>In an interview on 03/22/24 at 12:37 p.m. with the DON she stated she was not aware of the central line dressing change not being changed timely. The DON stated she expected the dressing change were completed weekly (7days), to prevent infection to the site. The DON stated she was responsible to follow up and make sure the central line dressings were completed timely and the DON had not checked Resident #250's central line dressing.</p> <p>Record review updated 07/2014, titled dressing change and injection port change of central venous catheter reflected, PURPOSE. To provide guidelines that will reduce risk for infection to the insertion or exit and the surrounding area of central venous catheter. There was no indication on how often/when the central line dressing was to be changed.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47030</p> <p>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.</p> <p>The facility failed to ensure foods were properly stored, labeled, and expired foods were discarded.</p> <p>This failure could have affected 83 of the 87 residents at the facility by placing them at risk for food exposed to adulteration or contaminants. Adulterated foods have had severe health effects. Diarrhea, nausea, allergic reactions, diabetes, and cardiovascular disease have been observed upon consumption of adulterated food.</p> <p>Findings included:</p> <p>Initial tour of the dry storage on [DATE] beginning at 5:40am revealed the following:</p> <p>3 bags of white corn 4 tortillas in a box labeled 6 flour tortillas with 6 flour tortillas.</p> <p>Observed a yellow/brown colored granular substance type item loosely wrapped in a heavy blue plastic, inside an acrylic container, unlabeled as to the contents with a date of [DATE].</p> <p>1 of 4 dented 4 pounds 2.5-ounce cans were on the shelf with the other canned items, instead of in the area labeled as Dented Cans Only, do not use.</p> <p>1 of 8 packages of tea bags were not labeled with a received or expiration date.</p> <p>An observation of a facility's refrigerator designated for resident use on [DATE] at 5:40am revealed the following:</p> <p>1 of 24 cups of cut fruit was not covered.</p> <p>3 of 3 16 ounces of Margarine was not labeled with a received or expired date.</p> <p>12 of 24 cups of dark liquid not labeled with contents, received date, or expiration date.</p> <p>An observation of a facility's freezer designated for resident use on [DATE] at 5:40am revealed the following:</p> <p>1 of 1 box of Tyson 8 piece cut chicken breast-98 individual pieces in an opened cardboard box sitting a shelf above boxes of bacon on a tray with blood leaking from below the box into the tray with the tray partially hanging off the shelf.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1 of 1 box of mixed food items altogether in one box with contents unlabeled, no received or expiration date.</p> <p>1 of 1 package of [NAME] observed with frostbite.</p> <p>2 of 2 chickens were on a shelf above 2 other shelves with food on them.</p> <p>Observation and Interview on [DATE] 5:40am-Observed dirty dishes on a rack in the dining room from the day prior. Observed Head Cook in the kitchen preparing food for the day. Head Cook revealed Dietary Manager was the Kitchen Manager. Head Cook revealed breakfast is served at 7am, Lunch at 12noon, dinner at 5pm. Head Cook revealed residents in the dining room were served first then the trays were taken to the halls for the nursing staff to serve the residents that ate in their room.</p> <p>[DATE] at 11:23am Interview with Dietary Manager and Dietitian revealed dietitian came weekly. During this interview Observed Head Cook temp the lunch food and Dietary Manager documented the temps. All temps were within normal range.</p> <p>[DATE] at 11:23am Interview with Dietary Manager revealed he had reviewed the kitchen for the items discussed that were out of expiration, dented cans, foods with frost bite, improperly thawing and found not stored properly. Dietary Manager stated he was responsible for ensuring food was stored properly and for training staff on food storage procedures. During this interview The Head cook, Dietary Manager stated he took care of the issues the facility failed to properly store and lable along with discharging the frost bitten food. The Dietitian revealed she visits the facility kitchen usually on a weekly basis and checks with the Dietary Manager about the diets. The kitchen line staff acknowledged the importance of properly stored food.</p> <p>Review of the U.S. Public Health Service Food Code dated 2017 reflected: XXX,d+[DATE].11 Packaged and Unpackaged Food -Separation, Packaging, and Segregation. (7) Storing damaged, spoiled, or recalled food being held in the food establishment as specified under S ,d+[DATE].11; .</p> <p>Review of U.S Department of Health and Human Services Food Code, dated 2017, revealed, ,d+[DATE].15 Package Integrity reflected: Food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the Food and Drug Administration Food Code, dated 2017, reflected, XXX,d+[DATE].12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food ,d+[DATE].11 Food Storage. (A) .food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination .(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety</p> <p>XXX,d+[DATE].12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food ,d+[DATE].11.</p> <p>(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations</p>		