STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676249	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carlyle at Stonebridge Park	170 Stonebridge Lane Southlake, TX 76092

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on observation, interview, and record review, the facility failed to provide care and services in accordance with the comprehensive assessment of a resident and consistent with the resident's needs and choices for activities of daily living including toileting for one (Resident #1) of four residents reviewed for ADL assistance. CNA A failed to provide Resident #1 with a bedpan for toileting and instead told the resident to use her brief on 12/04/24. This failure could place residents at risk of feeling uncomfortable, disrespected, have a decreased self-esteem and a diminished quality of life. Findings included: Record review of Resident #1's Nursing Home Comprehensive MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] with a principal diagnosis of a fracture of shaft of the left femur. The resident had a BIMS score that reflected the resident was cognitively intact. The MDS did not reflect the resident needed assistance with toileting. Record review of Resident #1's Progress Notes dated 11/29/24 reflected: Continent of bowel and bladder. Uses bedpan. Extensive assists x 1 person with ADLs, per LVN C. Interview on 01/21/25 at 1:50 PM with Resident #1 revealed she was told to use her brief when she used her call light to ask for assistance for toileting. Resident #1 stated she could not walk and required a bedpan. Resident #1 also stated CNA A came into her room to respond to her call light on 12/05/24. Resident #1 said she was told by CNA A to use her brief because she did not have time to assist her. (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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/22/25 at 9:36 AM with LVN B revealed she had not personally heard any staff tell a resident to use their brief instead of assisting with toileting the resident. LVN B stated she was told by Resident #1 that CNAs told her to use her brief because the aide did not have time to get a bedpan and assist the resident. LVN B said Resident #1 did not give her a specific name of a CNA. LVN B stated she did not report the incident because Resident #1 did not give her a specific name of a CNA. LVN B stated this was not the correct protocol, and the aide should have assisted the resident by providing her with a bedpan. LVN said if a resident must use her brief as told by a CNA, this was a dignity issue and could lead to skin breakdown. LVN B revealed the last time she was in-serviced on ADLs was upon her hire. Interview on 01/21/25 at 3:33 PM with CNA A revealed she assisted Resident #1 with toileting by providing her with a bedpan. CNA A stated she would open the bathroom door and stand there while the resident used the bedpan to give her privacy. CNA A said she would not leave a resident on the bedpan for more than five minutes. CNA A revealed she had told a resident to use their brief because there was not enough staff to assist the residents. CNA A stated she did not think it was Resident #1 she told to use her brief, but she could not recall who the resident was. However, CNA A stated she knew it was a resident on the same hall as Resident #1. CNA A stated she thought she was helping the resident because it was giving them relief, that someone came to check on them. CNA A said she was last in-serviced on 01/19/25 on ADLs. Interview on 01/21/25 at 4:44 PM with the ADON revealed she was unaware a staff member had told any residents to use their briefs instead of assisting them with toileting or bringing them a bedpan. The ADON stated she expected her staff to assist a resident with toileting if the resident needed assistance. The ADON also said a nurse could assist as well as an aide. The ADON revealed if she heard this occur or if it was reported to her that a staff member told a resident to use their brief, she would conduct a one-on-one training with the staff. Interview on 01/21/25 at 4:54 PM with the DON revealed the only time a resident should wait for assistance to toilet was when staff were passing trays. The DON stated if a resident needs to be changed or assistance with toileting, the CNA or nurse should stop and change them at that time. The DON stated she was unaware a staff member had told a resident to use her brief because there was not enough staff to assist her with toileting. The DON said a resident using her brief could lead to skin break down. The DON also stated this would be a dignity issue for the resident. The DON revealed she would begin in-servicing her staff immediately on the topic. Record review of the facility's Resident Rights policy, dated November 2016, reflected: . (1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. (2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition or payment source .