

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/24/2025
NAME OF PROVIDER OR SUPPLIER  The Carlyle at Stonebridge Park		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record review, the facility failed to ensure that residents who received nutrition by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 of 3 residents (Resident #1) reviewed for enteral feeding.</p> <p>The facility failed to follow physician's orders of providing Resident #1 with his 22 hours of feeding intake on 05/24/25.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 05/24/25 and ended on 05/25/25. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk for a decline in health or adverse effects due to inappropriate management of G-tube care.</p> <p>Findings included:</p> <p>Record review of Resident #1's admission Record dated 06/24/25 reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE].</p> <p>Record review of Resident #1's admission MDS assessment dated [DATE] reflected his diagnoses included dementia (loss of memory), gastro-esophageal (stomach acid flows back up into the esophagus and causes heartburn), hypertension (high blood pressure), Parkinson's disease, and seizure disorder. Resident #1's BIMS score was not completed due to Resident was rarely/never understood. MDS Section K - Swallowing/Nutritional Status indicated the resident's nutritional approach was a feeding tube.</p> <p>Record review of Resident #1's care plan revised date 05/27/25 reflected: Focus: The resident requires tube feeding r/t Dysphagia. provide Isosource 1.5 70cc/hr X 22 hours. Goal: The resident will maintain adequate nutritional and hydration status aeb weight stable, no s/sx of malnutrition or dehydration through review date. Interventions: Provide care to G-Tube site as ordered and monitor for s/sx of infection. RD to evaluate quarterly and PRN. Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed. The resident is dependent with tube feeding and water flushes. See MD orders for current feeding orders.</p> <p>Record review of Resident #1's Order Summary Report reflected Isosource 1.5 Cal Oral Liquid (Nutritional Supplements) Give 70 ml via G-Tube every shift for Nutrition. Order date: 04/22/2025.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/24/2025
NAME OF PROVIDER OR SUPPLIER  The Carlyle at Stonebridge Park		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's May 2025 MAR reflected Isosource 1.5 Cal Oral Liquid (Nutritional Supplements) Give 70 ml via G-Tube every shift for Nutrition. MAR indicated Resident #1 feeding was documented as given on 05/24/25 - day and evening.</p> <p>Record review of the facility's Provider Investigation Report, completed by the Administrator on 05/02/25, reflected the following:</p> <p>05/24/2025</p> <p>The facility initiated an investigation on 05/25/2025, after resident feeding tube was unhooked around 11:30am in order to lift him off the floor when he fell. The feeding tube was not hooked back up to his body until 11pm.</p> <p>Investigation Summary: Resident suffered a fall in his room. Fall did not result in any physical harm to resident. Resident feeding tube [was detached in under to lift him up off the ground]. This incident took place at approximately 11:30am. Nurse forgot to reattach the feeding to resident body once he was lifted up off of the floor. Feeding remains unattached until 11pm when resident's daughter brought it to the nurse's attention. Feeding was reattached at that time. All resident with feeding were checked to ensure it was attached to their bodies. Resident's skin assessed by Treatment Nurse. There are no skin break down, wounds on resident's body, or signs of dehydration. Resident weight checked and he was not experienced any weight lost. Physician ordered labs. Lab results shows that resident has not experience any changes from baseline.</p> <p>Assessment: Head to toe assessment and pain assessment completed. Resident did not have any changes of condition or any adverse effect.</p> <p>Provider Action: Staff in-service on Abuse/Neglect and G-Tube Attachment. Facility initially placed alleged perpetrator on suspension, pending investigation. Facility now moving forward terminating staff member, post investigation.</p> <p>Observation on 06/24/25 at 9:50 AM revealed Resident #1 in the common area sitting in his wheelchair. He could not answer questions. Resident #1's was connected to his feeding pump and the feeding pump was running.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/24/2025
NAME OF PROVIDER OR SUPPLIER  The Carlyle at Stonebridge Park		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and observation on 06/24/25 at 12:56 PM, Resident #1's Family Member revealed on 05/24/25 Resident #1 was not provided with his g-tube feedings for about 11 hours. She stated she had a camera in the room and in the footage, it showed around 10:45 PM Resident #1 had a fall in his room and landed on the right side of his bed. She stated the feeding pump was on the left side of the resident's bed, and when the resident was on the floor, she got concerned that the resident might had pulled his g-tube. Resident #1's Family Member stated when she reviewed the camera footage, she noticed Resident #1 was not connected to his feeding pump. Resident #1's Family Member stated she continued to review camera footage, and it showed Resident #1 being disconnected from his g-tube at 11:25 AM. She stated she contacted the facility, and the nurse entered the room and connected Resident #1's feeding tube at 10:54PM on 05/24/25. Observed camera video footage stamp date 05/24/25 at 11:32 AM Resident #1's feeding pump being disconnected from resident by LVN A but left feeding pump on. At 11:50 AM, LVN A observed entering the Resident #1's room due to feeding pump beeping and LVN A turned the feeding pump off. At 12:43PM, Resident #1 was transported out the room by CNAs. G-tube feeding pump was left in the room. At 7:44 PM, Resident #1 returned back to room, CNA B and LVN A transferred Resident #1 back to bed and CNA B provided incontinent care. At 7:48 PM, Resident #1 in bed resting, resident feeding pump was on the left side of Resident #1's bed turned off. Between 10:35 PM - 10:44PM, Resident was observed slowly moving towards his right side of the bed, slide off the bed and landed on his knees. Resident #1's feeding pump was off. At 10:45 PM, LVN D entered the room with another staff, resident was transferred back in bed and was connected to his feeding pump at 10:54 PM.</p> <p>An attempt was made to contact LVN A by phone on 06/24/25 at 2:07 PM; however, there was no answer.</p> <p>An attempt was made to contact CNA B by phone on 06/24/25 at 2:19 PM; however, there was no answer.</p> <p>Interview on 06/24/25 at 5:00 PM, Physician revealed he was made aware of Resident #1 not receiving his feeding. He stated he could not recall how many hours he was off his feeding, but the nurse forgot to connect the resident. He stated he ordered a bolus feeding and lab work. He stated he reviewed Resident #1 lab work, and everything was fine. He stated there was no risk to the resident. He stated his expectation were for nursing staff to follow the orders.</p> <p>Interview on 06/24/25 at 5:05 PM, the DON revealed she received a call from Resident #1's Family Member around 11:30PM/midnight regarding Resident #1's g-tube not being attached. She stated she contacted the facility but by that time Resident #1 feeding pump was already running. She stated she contacted LVN A and LVN A stated she had forgot to attach Resident #1. She stated LVN A just kept saying oh my god, oh my god. The DON stated the doctor was notified and the doctor ordered an extra bolus feeding, and lab work to ensure there was no dehydration. She stated Resident #1's lab work results were good. She stated the dietician was also informed and Resident #1's weight had been stable. The DON stated they had the nurse check on the other residents who were on g-tubes with no concerns noted. She stated all nursing staff were in-serviced on abuse and neglect and monitor feeding tubes to make sure that they are connected at all times according to the doctor orders. She stated LVN A was suspended pending investigation and once investigation was concluded she was terminated. She stated the potential risk of not following physician orders could be weight loss and dehydration.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/24/2025
NAME OF PROVIDER OR SUPPLIER  The Carlyle at Stonebridge Park		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 06/24/25 at 5:20 PM, the Administrator revealed LVN A admitted to forgetting to connect Resident #1 to his feeding. He stated after concluding his investigation he substantiated the incident. He stated his expectations were for his nursing staff to complete rounds, follow physician orders and make sure residents with g-tubes are connected. He stated if a resident was on continues feedings, and the resident was taken to another place in the facility the feeding pump should go with the residents. He stated the potential risk of a resident not receiving his feedings would be skin breakdown and dehydration.</p> <p>Record review of facility Administration of Formula via Feeding Tube Gravity, Bolus, Pump policy, reviewed date March 2019, reflected the following:</p> <p>To administer nutrients to patients who are unable to eat normally without complications: to assure proper absorption of nutrients by proper administration, without side effects</p> <p>The facility took the following actions to correct the noncompliance:</p> <p>Record review of Resident #1' physician orders reflected Resident #1 had an order for Enteral Feed Order one time only for 1 Day give x 1 bolus feeding (237ml) now of isosource 1.5 cal dated 05/25/25.</p> <p>Record review of Resident #1's Weight reflected no weight loss.</p> <p>Record review of Resident #1's Un-witnessed Fall (Skin assessment, Pain assessment) and Medication Error Assessment completed on 05/24/25 and 05/25/25 documented no concerns.</p> <p>Record review of the facility's In Service Training, dated 05/25/25, provided by the DON, reflected all facility nursing staff were In-Serviced on Abuse and Neglect, Monitor feeding tubes to make sure that they are connected at all time according to the doctors orders, Make sure g-tube are connected.</p> <p>Record review of Resident #1's Lab Results Report completed on 05/28/25 reflected normal levels.</p> <p>Interviews on 06/24/25 from 2:46 PM to 4:00 PM with ADON C, LVN E, LVN F, LVN G, LVN H, RN I, RN J, LVN K, LVN L, ADON M who work the shift of 6:00AM - 2 PM, and 2PM - 10 PM. Facility staff were able to verify education was provided to them. Facility staff were able to verify education was provided to them. The nursing staff stated they were educated on different types of abuse/neglect and residents on g-tubes. Nursing staff stated they were inserviced on making sure residents on g-tube were connected to feeding pumps according to physician orders, if residents on continues feedings were taken out of the room the feeding pumps must go with them. Staff stated they completed rounds during shift change with the incoming staff. Staff provided the types of abuse were physical, mental, financial, and verbal. Staff revealed they would report to the Abuse Coordinator, the Administrator, immediately if they witnessed any type of abuse or neglect.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 05/24/25 and ended on 05/25/25. The facility had corrected the noncompliance before the survey began.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/24/2025
NAME OF PROVIDER OR SUPPLIER  The Carlyle at Stonebridge Park		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure the clinical records were maintained in accordance with accepted professional standards and practices and were complete and accurately documented for 2 of 5 residents (Resident #1 ad Resident #2) records reviewed for treatment documentation.</p> <p>1. LVN A documented Resident #1 had received his g-tube feeding on 05/24/25 morning and evening, but the resident did not receive his feeding for approximately 11 hours.</p> <p>2. The facility failed to document wound care treatments on the Treatment Administration Record for Resident #2 indicated by blanks on Resident #2's June 2025 TAR.</p> <p>These failures could affect the residents medical record not being an accurate representation of the resident's medical condition or medical needs.</p> <p>Findings included:</p> <p>Record review of Resident #1's admission Record dated 06/24/25 reflected the resident was an [AGE] year-old male who admitted to the facility on [DATE].</p> <p>Record review of Resident #1's admission MDS assessment dated [DATE] reflected his dementia (loss of memory), gastro-esophageal (stomach acid flows back up into the esophagus and causes heartburn), hypertension (high blood pressure), Parkinson's disease, and seizure disorder. Resident #1's BIMS score was not complete due to Resident is rarely/never understood. MDS Section K - Swallowing/Nutritional Status indicated the resident's nutritional approach was a feeding tube.</p> <p>Record review of Resident #1's care plan revised date 05/27/25 reflected: Focus: The resident requires tube feeding r/t Dysphagia. provide Isosource 1.5 70cc/hr X 22 hours. Goal: The resident will maintain adequate nutritional and hydration status aeb weight stable, no s/sx of malnutrition or dehydration through review date. Interventions: Provide care to G-Tube site as ordered and monitor for s/sx of infection. RD to evaluate quarterly and PRN. Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed. The resident is dependent with tube feeding and water flushes. See MD orders for current feeding orders.</p> <p>Record review of Resident #1's Order Summary Report reflected Isosource 1.5 Cal Oral Liquid (Nutritional Supplements) Give 70 ml via G-Tube every shift for Nutrition. Order date: 04/22/2025.</p> <p>Record review of Resident #1's May 2025 MAR reflected Isosource 1.5 Cal Oral Liquid (Nutritional Supplements) Give 70 ml via G-Tube every shift for Nutrition. MAR indicated Resident #1 feeding was documented as given on 05/24/25 - day and evening.</p> <p>Observation on 06/24/25 at 9:50 AM revealed Resident #1 in the common area sitting in his wheelchair. He could not answer questions. Resident #1's was connected to his feeding pump and the feeding pump was running.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/24/2025
NAME OF PROVIDER OR SUPPLIER  The Carlyle at Stonebridge Park		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview and observation on 06/24/25 at 12:56 PM, Resident #1's Family Member revealed on 05/24/25 Resident #1 was not provided with his g-tube feedings for about 11 hours. She stated she had a camera in the room and in the footage, it showed around 10:45 PM Resident #1 had a fall in his room and landed on the right side of his bed. She stated the feeding pump was on the left side of the resident's bed, and when the resident was on the floor, she got concerned that the resident might had pulled his g-tube. Resident #1's Family Member stated when she reviewed the camera footage, she noticed Resident #1 was not connected to his feeding pump. Resident #1's Family Member stated she continued to review camera footage, and it showed Resident #1 being disconnected from his g-tube at 11:25 AM. She stated she contacted the facility, and the nurse entered the room and connected Resident #1's feeding tube at 10:54PM on 05/24/25. Observed camera video footage stamp date 05/24/25 at 11:32 AM Resident #1's feeding pump being disconnected from resident by LVN A but left feeding pump on. At 11:50 AM, LVN A observed entering the Resident #1's room due to feeding pump beeping and LVN A turned the feeding pump off. At 12:43PM, Resident #1 was transported out the room by CNAs. G-tube feeding pump was left in the room. At 7:44 PM, Resident #1 returned back to room, CNA B and LVN A transferred Resident #1 back to bed and CNA B provided incontinent care. At 7:48 PM, Resident #1 in bed resting, resident feeding pump was on the left side of Resident #1's bed turned off. Between 10:35 PM - 10:44PM, Resident was observed slowly moving towards his right side of the bed, slide off the bed and landed on his knees. Resident #1's feeding pump was off. At 10:45 PM, LVN D entered the room with another staff, resident was transferred back in bed and was connected to his feeding pump at 10:54 PM.</p> <p>An attempt was made to contact LVN A by phone on 06/24/25 at 2:07 PM; however, there was no answer.</p> <p>An attempt was made to contact CNA B by phone on 06/24/25 at 2:19 PM; however, there was no answer.</p> <p>Interview on 06/24/25 at 5:05 PM, the DON revealed she received a call from Resident #1 Family Member around 11:30PM/midnight regarding Resident #1's g-tube not being attached. She stated she contacted the facility but by that time Resident #1 feeding pump was already running. She stated she contacted LVN A and LVN A stated she had forgot to attach Resident #1. She stated LVN A just kept saying oh my god, oh my god. She stated during the investigation, she also noticed LVN A documented that the feedings were provided to Resident #1 when he did not. She stated when she questioned LVN A about the documentation LVN A got mad and ended the call. She stated LVN A was suspended pending investigation and once investigation was concluded she was terminated. She stated her expectations were for all nurses to document as they go and document what was being completed. She stated it was the responsibility of all nurses to document accurately and it was the responsibility of the ADONs and herself to ensure it was being done correctly. She stated the potential risk of not documenting correctly would be not being able to get history of what happened with the resident.</p> <p>Interview on 06/24/25 at 5:20 PM, the Administrator revealed LVN A admitted to forgetting to connect Resident #1 to his feeding. He stated after concluding his investigation he substantiated the incident. He stated during the investigation it was also confirmed LVN A documented the feedings were provided when they were not. He stated they took disciplinary actions and terminated LVN A.</p> <p>2. Record review of Resident #2's admission Record dated 06/24/25 reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/24/2025
NAME OF PROVIDER OR SUPPLIER  The Carlyle at Stonebridge Park		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #2's quarterly MDS assessment dated [DATE] reflected his diagnoses included heart failure, hypertension (high blood pressure), hypothyroidism (the thyroid gland doesn't make enough thyroid hormone), colostomy status (opening stoma in the abdominal wall). Resident #2's BIMS score was 11 indicating moderate cognitive impairment.</p> <p>Record review of Resident #2's care plan revised date 04/15/25 reflected: Focus: Pressure Ulcer Prevention. Goal: The resident will remain free of skin breakdown over the next through the next review date. Interventions: Therapy disciplines to screen, evaluate, and treat as indicated.</p> <p>Record review of Resident #2 revealed no records were recorded of Resident #2 receiving wound care treatment on right lateral leg on 06/02/25, 06/04/25, 06/06/25, 06/11/25, 06/13/25, 06/16/25, 06/18/25, 06/18/25 and on 06/23/25 as indicated by blanks on the Treatment administration record.</p> <p>Record Review of Resident #2 progress notes for June 2025 did not reflect alternative documentation of wound treatments of the right lateral leg.</p> <p>Record review of physician orders dated 05/02/25 revealed Wound Treatment - Xeroform every evening shift every Mon, Wed, Fri for Skin tear wound Cleanse wound to Right Lateral leg with Normal Saline or Skin Cleanser. Pat Dry. Apply Xeroform to wound. Cover with Island Dressing.</p> <p>Observation and interview on 06/24/25 at 11:40 AM revealed Resident #2 in her bed in her room. Resident #2 stated she got her wound care three times a week and before she was getting wound care daily. She denied missing wound treatment.</p> <p>Observation/skin assessment on 06/24/25 at 11:56 AM with LVN D revealed she explained the procedure to Resident #2, she washed hands, put on gloves and positioned the resident. Resident #2 trauma/injury right superior lateral leg dressing was observed dated 6/24/25 and the dressing was intact and clean.</p> <p>Interview on 06/24/25 at 12:45 PM with wound care nurse revealed she was the wound care nurse. She stated she was aware she was supposed to document on treatment administration record every time she performed wound care, but she was not aware that every time she documented it was not showing on the treatment administration record. She stated the risk of not documenting after the wound care was done would mean treatment not administered and would be hard to monitor if the wound was getting better or not because it would be hard to tell when the wound care was last provided. She stated the facility policy was to sign the treatment administration record after wound care was performed. She stated she could not recall in-service on documentation since she was newly hired.</p> <p>Interview on 06/24/25 at 03:32 PM with the DON revealed her expectations were that staff to document accurately on the resident's treatment administration record. The DON said wound care nurse should have documented on Resident #2's treatment administration record that she had performed wound care. She stated she was the one responsible of ensuring the wound care was done and documented on treatment administration record/Medication administration record. The DON stated she does random checks on big pressure ulcer wounds but not skin tears. She said the purpose of documenting accurately was to make sure orders were completed correctly. The DON said the risk of staff not documenting care accurately could lead to care not being provided and the wounds would deteriorate. She stated she could not recall training on documentation to the staff since she had not noticed there was an issue with documentation of wound care.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/24/2025
NAME OF PROVIDER OR SUPPLIER  The Carlyle at Stonebridge Park		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of facility Documentation of Medication Administration on eMAR/eTAR, dated February 2010 reflected the following:</p> <p>To ensure proper documentation of medication administration and treatments in the medical record.</p>