

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/08/2026
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.			
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the interdisciplinary team determined if a resident was able to self-administer medications for 3 of 33 residents (Resident #41, Resident #115 and Resident #118) reviewed for resident rights.1.The facility's interdisciplinary team failed to ensure Resident #41 was clinically appropriate to self-administer Fluticasone Propionate Nasal Spray, Azelastine HCL and Major Deep Sea Premium Saline Nasal Spray that were at the resident's bedside.2.The facility failed to ensure Resident #115, with nasal spray at her bedside, was clinically appropriate to self-administer medications that were at the resident's bedside.3. The facility failed to ensure Resident #118 was clinically appropriate to self-administer cough syrup that were at the resident's bedside. The failure had the potential to place residents at risk for unsafe drug administration.Findings included:1.Record review of Resident #41's quarterly MDS assessment, dated 11/14/25, reflected she was an [AGE] year-old female who admitted to the facility on [DATE]. The residents' diagnoses included chronic systolic heart failure (heart muscle weakens and cannot pump enough blood to meet the body's needs), hypothyroidism (thyroid gland does not make enough hormone into bloodstream), and chronic total occlusion of coronary artery (coronary arteries blockage). Resident #41's BIMS score was 10 which indicated moderate cognitive impairment.Record review of Resident #41's Care Plan, revised date 12/07/25, reflected no indication of Resident #41 able to self-administer any medications. Record review of Resident #41's clinical records reflected no assessment was completed to indicate if Resident #41 was able to self-administer any medication. Record review of Resident #41's order summary report reflected the following: Fluticasone Propionate Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal)) 2 sprays in both nostrils two times a day for allergy -Start Date - 05/01/2025. Resident #41 had no physician orders for the use of Azelastine HCL (nasal spray) and Major Deep Sea Premium Saline (nasal spray). Observation and interview on 01/06/26 at 11:27 AM, revealed Resident #41 had a bottle of Fluticasone Propionate Nasal Spray, a bottle of Azelastine HCL (nasal spray), and another bottle of Major Deep Sea Premium Saline (nasal spray) at her bedside table. Resident #41 stated she had the bottles for a long time, and the staff were aware of it. She stated staff had not mentioned anything to her about keeping them in her room. Resident #41 stated she administered the nasal spray twice a day. She stated staff come by to ensure she administered them. Interview on 01/07/26 at 1:34 PM, LVN C revealed she was the nurse assigned to 700 Hall and had no residents in her hall that could self-administer any medications including nasal spray. She stated she was the nurse assigned to Resident #41. LVN C observed three bottles of nasal sprays at Resident #41's bedside table. She stated she was not aware Resident #41 had three bottles of nasal spray and indicted Resident #41 only had an order for the Fluticasone Propionate nasal spray. She stated she was not sure where the other two nasal sprays came from. LVN C stated residents were not supposed to keep medications or nasal spray at bedside. She stated residents needed to be assessed first to ensure they could self-administer any medication and needed to be care plan for it. LVN C stated the potential risk of keeping medications at the bedside would be the resident using the medication out of doctor's orders. Interview on 01/08/26 at 4:32 PM, ADON A revealed there were no residents in the facility who could self-administer any medications. She stated (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the residents needed to be assessed first, obtained a physician's order to self-administer, educate the residents, provide a lock box, and care plan. ADON A stated LVN C notified her about Resident #41 having bottles of nasal sprays at bedside. She stated Resident #41 had not been assessed or had a physician order for her to self-administer any nasal spray medication. She stated the potential risk would be resident over medicate themselves or someone else take the medication. 2.Record review of Resident #115's admission MDS, dated [DATE], reflected Resident #115 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #115's BIMS had not been completed. Resident #115's MDS was pending completion. Record review of Resident #115's undated Baseline Care Plan did not address Resident #115's need or use of medications at her bedside. Record review of Resident #115's clinical records reflected no assessment was completed to indicate if Resident #115 was able to self-administer medication. Record review of Resident #115's order summary report reflected the following: Fluticasone Propionate Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal)) 2 sprays in both nostrils one time a day for nasal Congestion Start date:1/3/2026 8:00 AM.Record review of Resident #115's MAR reflected Resident #115 was administered Fluticasone Propionate Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal)) 2 sprays in both nostrils one time a day for nasal Congestion Start date:1/3/2026 8:00 AM on 01/04/26, 01/05/26, 01/06/26, 01/07/26, and 01/08/26.Observation and interview on 01/06/26 at 10:57 AM, revealed Resident #115 had a bottle of Fluticasone Propionate Nasal Spray 50 mcg at her bedside. Resident #115 stated she had the medication since being admitted on [DATE] from the hospital. Resident #115 stated she kept the medication at her bedside because sometimes her nose got dry, and she used it as needed to keep her breathing comfortably. Resident #115 stated she was not sure if staff knew she had the nasal spray, but they never took them away from her. Interview on 01/06/26 at 11:20 AM, the Staffing Coordinator was observed exiting Resident #115's room. The Staffing Coordinator revealed she was fairly new to working the floor and was helping to answer the call light. The Staffing Coordinator stated she just changed Resident # 115; however, she did not see the nasal spray at the bedside table. The Staffing Coordinator stated she was not sure if there were any residents who could self-administer their own medications and medications should not be kept at residents' bedside. The Staffing Coordinator observed the nasal spray at Resident #115's bedside table and stated she would follow up with the Charge Nurse. The Staffing Coordinator stated all staff were responsible for removing any medications found in resident rooms. The Staffing Coordinator further stated not doing so placed residents at risk of misusing the medication. Interview on 01/06/26 at 12:19 PM, ADON B revealed there were no residents able to have medications at their bedside or self-administer medications due to risk of overdosing. ADON B stated she was notified by LVN F that Resident #115 had a nasal spray at her bedside. ADON B stated she was told by LVN F that she had attempted to remove the nasal spray previously and Resident #115 had refused to release the medication but today she was able to remove the nasal spray. ADON B stated she expected nursing staff to remove any medication found in resident rooms, contact the family to pick it up or store the medication on the nursing carts. ADON B further stated the physician should be called to notify them medication was found at the bedside and consult for a prescription to administer to the resident from the nursing cart. Interview on 01/06/26 at 1:45 PM LVN F stated she was previously informed that Resident #115 had the nasal spray at her bedside, however, did not want to release the medication and had been hiding the medication in her bed. LVN F stated she explained to Resident #115 that there needed to be a physician's order to have use of the medication while in the facility. LVN F stated Resident #115 was afraid that she would not have access to the medication as needed or had a stuffy nose. LVN F stated she educated Resident #115 that if she needed the medication, she would inform the nursing staff which could administer the nasal spray in a safe manner. LVN F stated she was able to remove the nasal spray and would contact the physician for an order. LVN F stated resident administering their own medications were at risk of not using the medication as prescribed, not talking it properly, and overdosing. LVN F stated nursing and medication aides were responsible (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for ensuring scheduled and prn medication were given at the right time for safety issues. Interview on 01/08/26 at 5:15 PM, the DON revealed she had no residents who could self-administer any medication or nasal spray. She stated residents were not allowed to keep medications at bedside unless a physician order had been obtained and the resident had been assessed to self-administer. She stated the potential risk of keeping medications at the bedside would be someone else could get the medication or the resident using the medication whenever. 3. Record review of Resident #118's admission MDS, dated [DATE], reflected Resident #118 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #118's BIMS had not been completed. Resident #118's MDS was pending completion. Record review of Resident #118's undated Baseline Care Plan, did not address Resident #118's need or use of medications at her bedside. Record review of Resident #118's clinical records reflected no assessment was completed to indicate if Resident #118 was able to self-administer medication. Record review of Resident #118's order summary report did not reflect an order or use of cough syrup. Record review of Resident #118's MAR did not reflect an order or use of cough syrup. Observation and interview on 01/06/26 at 12:00 PM revealed Resident #118 had a medication cup full of dark liquid at his night stand. Resident #118 stated he was in a car accident, and he sometimes had a cough when he tried lying flat or tried to catch his breath. Resident #118 stated family members were just visiting and left the medication in the cup on his nightstand. Resident #118 stated he had not used the cough syrup. Observation and interview on 01/06/26 at 12:19 PM with ADON B revealed was not sure what medication was in the medication cup, she stated she was just in the room with Resident #118 and assisted with his bed bath. ADON B asked Resident #118 to identify what was in the cup and he stated it was cough syrup provided by his family members. ADON B explained to Resident #118 that she had to remove the medication and contact the physician to ensure he was able to have cough medication. ADON B removed the cough syrup in the medication cup and removed the medication bottles from the family bag at the night stand. ADON B stated that in order for residents to have medication at their bedside an assessment was required, ADON B stated no resident in the facility had been assessed to self-administer their own medications. According to ADON B all staff were responsible for removing any medication found in resident rooms. ADON B stated residents with access to medications in their room could be placed at risk of having negative interactions with other medications or double dosing. Interview on 10/08/25 at 4:00 PM, the DON revealed she did not have any residents in the facility who could self-administer their own medications. The DON stated if the resident wanted to keep medications at her bedside a physician order had to be obtained. She stated the potential risk of keeping medications at the bedside would place residents at risk of over medicating. The DON stated the expectation of all staff was to remove any medications found in resident rooms and inform the charge nurse immediately. The DON stated the charge nurse would be responsible for ensuring all medications were removed, contact the physician and educate family and residents to turn in medications to the nursing station and not directly to residents. Record review of facility Self-Administration of Medication policy, revised February 2021, reflected the following: Residents have the right to self-administer medications if the interdisciplinary team had determined that it is clinically appropriate and safe for the resident to do so. 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 44 residents (Resident #45) reviewed for quality of care. The facility failed to obtain physician orders for the use of an arm sling and leg brace for Resident #45. This failure placed residents at risk of not receiving appropriate care and worsening of their conditions. Findings included: Record review of Resident #45's admission MDS assessment, dated 10/06/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #45 had diagnoses that included stroke (loss of blood flow to part of the brain), muscle weakness (loss of strength to move, felt as difficulty with tasks, balance issues, or trembling), abnormalities of gait and mobility. He had a BIMS score of 9, which indicated his cognition was. The moderately impaired. MDS reflected Resident #45 had functional limitation in range of motion, impairment on one side for upper and lower extremity. Resident #45 used a walker and wheelchair for mobility. Record review of Resident #45's care plan, undated, reflected Resident #45 had Activity of Daily Living self-care performance deficit related to right side weakness due to stroke. Goals included to maintain current level of function. Interventions included Resident #45 required assistance by 1 or 2 staff to dress. This may fluctuate with weakness, fatigue, and weight bearing status. SKIN INSPECTION: Observe for redness, open areas, scratches, cuts, bruises, and report changes to the Nurse. Monitor/document/report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Record review of Resident #45's undated care plan did not address his need, use for an arm sling, or leg brace. Record review of Resident #45's physician orders dated 01/08/26 did not reveal the use of an arm sling or leg brace. Observation and interview on 01/06/26 at 2:26 PM revealed Resident #45 with an arm sling and wrap on his right arm along with a leg brace on his right leg. Resident #45 expressed the use of the arm sling, and the leg brace was used due to him having a stroke and he required the use of the devices. According to Resident #45 he has utilized both devices for at least two years. Resident #45 stated he wore both devices daily, and he required assistance daily to administer the devices. Interview and observations on 01/08/26 at 2:23 with CNA J revealed Resident #45 with his right arm wrapped with an elastic wrap along with an arm sling. Resident #45 also wore a leg brace on his right leg. CNA J stated Resident #45 had utilized these devices for at least 3 months. CNA J stated, Resident #45 usually asked me for assistance daily to administer the devices. CNA J stated Resident #45 liked to be independent as much as possible with his activities of daily living skills and these devices helped him to do. CNA J stated Resident #45 had not had any injuries or skin condition from wearing either device. Interview on 01/08/26 at 2:00PM with ADON B revealed she had observed Resident #45 with the use of both an arm sling and leg brace. ADON B stated she thought Resident #45's orders were placed in the clinical record for use of the arm sling and the leg brace. ADON B stated it was the responsibility of the nurses to place orders for the use of Resident #45's devices. ADON B stated not addressing the use of Resident #45's devices placed him at risk of delayed monitoring or treatment of skin conditions, also improper fit and wearing of the devices. Interview on 01/08/26 at 2:23 PM with the DON revealed there should be orders in place if Resident #45 was wearing devices. The DON stated he should have been evaluated by the therapy department, and received orders from them, orders entered by her, ADON or his charge nurse. The DON stated she expected all staff to work together to ensure to have all the right things in place so that Resident #45 could get the greatest benefit out of using the arm sling and leg brace. The DON stated not doing so placed Resident #45 at risk for skin conditions. Interview on 01/08/26 at 2:40 PM with Director of Rehabilitation revealed she knew Resident #45 utilized an arm sling and leg brace for his right-side extremities. The Director of Rehabilitation stated Resident #45 entered the facility with both devices. The Director of (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Rehabilitation Resident #45 was not currently on therapy services therefore, nursing staff would be responsible for placing orders with the physician. The Director of Rehabilitation stated not having an order and effectively monitoring Resident #45 with his devices placed him at risk of having skin conditions due to the continued use of devices. Record review of the facility's Activities of Daily Living dated June, reflected the following: A Nursing Restorative Care Program is written for the individual needs of the Patients must be maintained in accordance with the Restorative Nursing Program. Patients wearing a medical device (split, brace, immobilizer, or other) will have their skin inspected (under the device) every shift and include documentation in the Treatment Administration Record. Note: If a medical device is used for orthopedic purposes a physician's order will be obtained.		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents received proper treatment and care to maintain good foot health by providing foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition 2 of 5 residents (Resident #42 and Resident #75) reviewed for foot care. The facility failed to provide Resident #42 and Resident #75 assistance with toenail care. Resident #42 and Resident #75 toenails were observed to be about half inch long on each foot. This failure could place the residents at risk for decreased feelings of self-worth and infection. Findings include: 1. Record review of Resident #42's Quarterly MDS assessment, dated 12/26/25, revealed Resident #42 was an [AGE] year-old female admitted to the facility on [DATE]. Resident #42 had cognition intact with a BIMS score of 04 (indicating severe cognitive impairment). Resident #42 required partial/moderate assistance from staff with shower/bathes and set up / clean up with personal hygiene. Active diagnosis included Arthritis (joint pain and stiffness), need for assistance with personal care, limitation of activities due to disability. Review of Resident #42's care plan, undated, revealed it did not address Self Care Performance Deficit. Further review revealed she had Diabetes. Goal: Resident will have no complications related to diabetes. Interventions included to check all body for breaks in skin and treat promptly as ordered by doctor. Interview and Observation on 01/06/26 at 12:05 PM with Resident #42 revealed her laying in bed, Resident #42 uncovered her legs and feet and stated, I wished they would cut my toenails, they said they didn't have anyone to do it. Resident #42 stated she felt her toenails were a bit long, she had spoken with someone to have them cut but they had not returned to do so. Observation and Interview on 01/08/26 at 10:01 AM with CNA E revealed Resident #42 laying in bed resting, CNA E asked Resident #42 if she could observe her feet and responded that Resident #42's toenails were long and needed to be cut. CNA E stated Resident #42's shower days were Tuesday, Thursday, and Saturdays during the 2-10:00 PM shift. CNA E stated that CAN's providing the shower were responsible for ensuring the toenails were cut or trimmed. CNA E stated she would be willing to address Resident #42's toenails however needed to consult with the nurse first. CNA E stated CNA's were supposed to indicate any nailcare on the shower sheets so that the Charge Nurse could address the issue or identify if the resident had a diagnosis of Diabetes, if that was the case the Nurse would be responsible to ensure that nailcare was provided by trimming or cutting the toenails. Interview on 01/08/26 at 10:10 AM with LVN F revealed Resident #42 had a diagnosis of Diabetes, and she was responsible for trimming, cutting her toenails. According to LVN F, residents that were Diabetic were also placed on the list to be seen by the podiatrist on a monthly basis. LVN F stated she worked closely with CNAs on the floor, and it was usually brought to her attention when she needed to trim or cut resident nails or toenails. LVN F stated she worked closely with Resident #42 and her family to keep her toenails trimmed however she had not paid much attention to Resident #42's toenails lately. According to LVN F, not keeping resident toenails trimmed and cut placed residents at risk of having a hang nail, nails getting too long, or they could scratch themselves. Interview on 09/18/25 at 10:37 AM with CNA F revealed resident nail care was to be completed during shower days however she usually paid attention to resident nails daily and would clean or trim them if needed. CNA F stated it was the responsibility of the aides to complete nail care and grooming for residents on their halls, not doing so placed residents at risk of scratching, or cutting themselves or others. 2. Record review of Resident #75's Quarterly MDS assessment, dated 10/01/25, revealed Resident #75 was a [AGE] year-old male admitted to the facility on [DATE]. Resident #75 had cognition intact with a BIMS score of 07 (indicating moderate cognitive impairment). Resident #75 required substantial/maximal assistance from staff with shower/bathes and with personal hygiene. Active diagnosis was high blood sugar. Review of Resident #75's care plan, undated, revealed Resident #75 had an Activities of Daily Living self-care performance deficit related to (continued on next page)		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unsteady gait and balance with cognitive deficits. Goals included to maintain current level of function. Interventions included Avoid scrubbing and pat dry sensitive skin. Check nail length and rim and clean on bath day and as necessary. Report any changes to the nurse. Resident required staff assistance for bathing/showers. Further review revealed he had Diabetes. Goal: Resident will have no complications related to diabetes. Interventions included to check all body for breaks in skin and treat promptly as ordered by doctor. Interview and Observation on 01/06/26 at 3:05 PM of Resident #75 laying in bed, Resident #75 had his right foot exposed showing his toenails measuring about half inch long. When asked about his toenails Resident #75 stated I would like someone to trim my toenails. Resident #75 stated that he should get his toenails trimmed by a doctor but was not sure when the last time he had his toenails trimmed. Interview on 01/08/26 at 10:30 AM with CNA I revealed she worked with Resident #75 in the past however he was currently on 2-10:00 PM shift for showers on Monday, Wednesday, and Fridays. CNA I stated she noticed how long Resident #75's toenails were, stating they were too long. According to CNA I, CNAs were responsible for showers which included indicating on the shower sheet if nails needed to be addressed. CNA I stated nurses reviewed the shower sheets and rounded weekly on Sundays to trim resident toenails and podiatry came monthly. CNA I stated not keeping resident toenails trimmed placed residents at risk of resident toenails growing long, introducing fungus and bacteria if not cleaned and trimmed as needed. Interview on 01/08/26 at 4:00 PM with DON revealed she expected residents to have hand hygiene which included nail care. The DON stated it was the responsibility of the CNAs to complete nail care if residents were not diagnosed with Diabetes, otherwise the charge nurse would trim and clean resident nails, or resident would be referred to podiatry. According to the DON if during the shower nail care was needed CNAs were to mark it on the sheet and nurse will sign off and address any concerns. The DON stated when nursing staff did not provide nail care it placed residents at risk of nails accumulating dirt, curling under and grown into resident's skin. Review of the facility's policy dated June 2025 titled Activities of Daily Living policy reflected: Every effort must be made to assure that assignments of nurses and nurse aides to Patients are as consistent as possible. A Kardex (documentation system that enables nurses to reference key patient information) must be prepared from the electronic medical record to assist direct care staff in providing assistance to Patients in their activities of daily living. A Nursing Restorative Program is written for the individual needs of the Patients must be maintained.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure all drugs and biologicals were stored securely for 2 of 33 residents (Resident #39 and Resident #118) on one hall reviewed for storage of medications. 1. The facility failed to ensure two pills (Zoloft and Memantine) were not left on the floor in Resident #39's room on 01/06/26. 2. The facility failed to ensure Resident #118 cough syrup was not left unattended at his bedside on 01/06/26. This failure could place residents at risk of consuming unsafe medications. Findings included: 1. Record review of Resident #39's annual MDS assessment, dated 12/02/25, reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. The residents' diagnoses included anxiety disorder (involve more than occasional worry or fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), hepatic encephalopathy (brain disorder caused by liver failure), and Non-Alzheimer's Dementia (brain condition that slowly damages your memory, thinking, learning and organizing skills). Resident #39's BIMS score was 10 which indicated moderate cognitive impairment. Record review of Resident #39's physician orders reflected the following orders: SERTRALINE TAB 25MG Give 1 tablet orally in the evening for depression Start date 05/02/25. MEMANTINE TAB HCL 5MG Give 1 tablet orally two times a day for Alzheimer's Start date 10/28/25. Record review of Resident #39's January 2026 MAR reflected SERTRALINE TAB 25MG Give 1 tablet orally in the evening for depression time 2000 (8:00 PM) and MEMANTINE TAB HCL 5MG Give 1 tablet orally two times a day for alzheimers (9:00 AM and 2100 (9:00PM) MAR indicated only Memantine was provided at 9:00AM on 01/06/26. Observation and interview on 01/06/2026 at 2:33 PM revealed to small pills located by Resident #39's closet door upon entrance to her room. Resident #39 stated she was provided with her medications, and she had taken them. She stated she could not recall who administered them to her. Resident #39 stated she did not know whose pills were on the floor, but she could assure the pills were not hers. Interview and observation on 01/06/26 at 2:41 PM with LVN D revealed he was the nurse assigned to Resident #39. Observed LVN D entered Resident #39's room and observed the pills on the floor and he picked them up. He identified the pills as Zoloft and Memantine tab. He stated he did not provide Resident #39 medications in the morning, he stated it was the DON. LVN D stated when he conducted his rounds, he did not notice the pills on the floor. LVN D stated the potential risk of leaving medications unattended would be someone else taking it. Interview on 01/07/26 at 2:52 PM with the DON revealed she administered medication on the 800 Hall on 01/06/26 and LVN D took over the medication chart at around 9:00 AM. She stated she provided Resident #39's medications and observed her take it. She stated LVN D informed her pills were found on the floor in Resident #39's room. She stated she did not administer those pills to the resident. The DON stated the expectation of when administering medications nurses should stay in the room and observe the resident take the medication. If a nurse drops a pill, they need to pick it up and put it in the biohazard. Potential risk of leaving medication unattended would be someone else picking it up and could cause harm. 2. Record review of Resident #118's admission MDS, dated [DATE], reflected Resident #118 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #118's BIMS had not been completed. Resident #118's MDS was pending completion. Record review of Resident #118's undated Baseline Care Plan, did not address Resident #118's need or use of medications at her bedside. Record review of Resident #118's clinical records reflected no assessment was completed to indicate if Resident #118 was able to self-administer medication. Record review of Resident #118's order summary report did not reflect an order or use of cough syrup. Record review of Resident #118's MAR did not reflect an order or use of cough syrup. Observation and interview on 01/06/26 at 12:00 PM revealed Resident #118 had a medication cup full of dark liquid at his night stand. Resident #118 (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER The Carlyle at Stonebridge Park		STREET ADDRESS, CITY, STATE, ZIP CODE 170 Stonebridge Lane Southlake, TX 76092	
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated he was in a car accident, and he sometimes had a cough when he tried lying flat or tried to catch his breath. Resident #118 stated family members were just visiting and left the medication in the cup on his night stand. Resident #118 stated he had not used the cough syrup. Observation and interview on 01/06/26 at 12:19 PM with ADON B revealed was not sure what medication was in the medication cup, she stated she was just in the room with Resident #118 and assisted with his bed bath. ADON B asked Resident #118 to identify what was in the cup and he stated it was cough syrup provided by his family members. ADON B explained to Resident #118 that she had to remove the medication and contact the physician to ensure he was able to have cough medication. ADON B removed the cough syrup in the medication cup and removed the medication bottles from the family bag at the night stand. ADON B stated that in order for residents to have medication at their bedside an assessment was required, ADON B stated no resident in the facility had been assessed to self-administer their own medications. According to ADON B all staff were responsible for removing any medication found in resident rooms. ADON B stated residents with access to medications in their room could be placed at risk of having negative interactions with other medications or double dosing. Interview on 10/08/25 at 4:00 PM, the DON revealed she did not have any residents in the facility who could self-administer their own medications. The DON stated if the resident wanted to keep medications at her bedside a physician order had to be obtained. She stated the potential risk of keeping medications at the bedside would place residents at risk of over medicating. The DON stated the expectation of all staff was to remove any medications found in resident rooms and inform the charge nurse immediately. The DON stated the charge nurse would be responsible for ensuring all medications were removed, contact the physician and educate family and residents to turn in medications to the nursing station and not directly to residents. Record review of facility Medication Labeling and Storage policy, revised February 2023, reflected the following: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate the assessment with the pre-admission screening and resident review (PASARR) program for one (Resident #49) of five resident assessments reviewed for PASARR evaluations. The facility did not refer Resident #49 to the appropriate state-designated mental health authority for review when she received a new diagnosis of bipolar disorder. This failure could affect residents with psychiatric diagnoses who may not be evaluated and receive needed PASARR services. The findings were: Record review of Resident #49's quarterly MDS assessment, dated 12/17/25, reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. The residents' diagnoses included anxiety disorder (involve more than occasional worry or fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), psychotic disorder (a collection of symptoms that affect the mind), schizophrenia (affects how people think, feel and behave), bipolar disorder (condition that causes extreme mood swings) and chronic diastolic heart failure (ventricle becomes stiffer than usual). Resident #49's BIMS score was 06 which indicated severe cognitive impairment. The MDS further revealed Resident #49 was currently taking antipsychotic medication. Record review of Resident #49's Care Plan revised date 12/06/25, reflected [Resident #49] uses psychotropic medications Zyprexa and Haldol r/t DX of Bipolar/Depression/anxiety. She is not eligible for PASRR Services d/t election of Hospice services. Goal: The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. Interventions: Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Discuss with MD, family re ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. Record review of Resident #49's PASARR Level 1 Screening, dated 04/23/25, reflected she did not have a mental illness. Review of Resident #49's listed diagnoses on 01/06/26 revealed she was diagnosed with schizoaffective disorder, unspecified on 11/21/25. Further review revealed she was diagnosed with schizoaffective disorder, bipolar type on 01/05/26. Interview on 01/08/26 at 9:37 AM, the MDS Coordinator revealed she was responsible for submitting PASARR's whether for newly admitted residents or related to updates for new diagnoses for residents. The MDS Coordinator stated if a resident was diagnosed with a new mental illness after they had a PASARR submitted already she was supposed to send a new PASARR level 1 or obtained a 1012 form; depending on if the resident had a primary diagnosis of dementia. MDS Coordinator stated she was informed Resident #49 did not require a new PAASSR level one because the resident was receiving hospice services and would not qualify. However, after completing her research she was wrong and needed to complete a new PASARR level 1. She stated no potential risk if a new PASARR level 1 was not submitted because the resident was already receiving psych services. Interview on 01/08/26 at 5:37 PM, the Administrator revealed MDS Coordinator was responsible for completing and updating the PASARR assessments and submitting them timely. The Administrator stated if a new diagnosis was given to a resident the MDS Coordinator should have followed up with the mental health authority. Potential risk for not submitting PASARR assessment would be the resident could miss services. Record review of facility's Resident Assessment - Coordination with PASARR Program policy, dated 12/1/25 reflected the following: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure necessary treatment and services to promote healing for 1 of 5 residents (Resident #10) reviewed for pressure ulcers. The facility failed to ensure Resident #10's Stage 3 pressure ulcer was covered with a dressing. This failure could place residents at risk of severe pain, and lead to systemic infections causing harm for residents. Findings included: Record review of Resident #10's quarterly MDS assessment, dated 11/20/25, reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. The residents' diagnosis was pressure ulcer of sacral region. Resident #10's BIMS score was 04 which indicated severe cognitive impairment. The MDS assessment Section M - Skin Conditions indicated Resident #10 was at risk of pressure ulcers and had an unhealed pressure ulcer. Record review of Resident #10's care plan, revised date 01/04/26, reflected: Focus: The resident has a Stage III pressure ulcer to Sacrum. Goal: The resident's pressure ulcer will show signs of healing and remain free from infection by/through review date. Interventions: Administer treatments as ordered and monitor for effectiveness. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Treatment to pressure ulcer per physician's order. Focus: Wound Management. Goal: Wound will be free of signs or symptoms of infection. Wound will show signs of improvement. Interventions: Provide wound care per treatment order. Review of Resident #10's physician orders dated 01/04/26 revealed Wound Treatment - Collagen and Calcium Alginate w/ Silver as needed to sacrum if dressing becomes saturated, soiled, or dislodged -Start Date-01/05/26. Observation on 01/08/26 at 1:12 PM, Resident #10's wound care was provided by Treatment Nurse and Wound Care NP. Resident #10's brief was removed, resident had wound to her sacrum that is open to air, no dressing in place. Resident #10 had moderate amount of soft stool, no stool on or near the wound. After peri care was completed, the wound was cleansed with wound cleaner, and wound bed was debrided. Wound bed has pink healthy tissue. Interview on 01/08/26 at 1:35 PM, Treatment Nurse revealed there should have been a dressing in place when she removed the brief. She stated Resident #10 had a hospice CNA visit in morning of 01/08/26 and received a bed bath, and the dressing probably came off at that time. She stated as far as she knew the CNAs had not alerted anyone of the need to replace the dressing. Interview on 01/08/26 at 1:38 PM, Wound Care NP revealed the lack of dressing to the wound when the brief was removed was not too concerning since there was no stool in the wound itself. He stated that is why a PRN order was written, so staff would know how to replace the dressing if it came off between wound care treatments. Interview on 01/08/26 at 1:40 PM, Resident #10 revealed she felt like her wound was healing well, had no complaints of pain during or after wound care. Unknown of when dressing came off. Interview on 01/08/2026 at 2:52 PM by phone, Hospice CNA revealed he was the CNA who visited Resident #10 today (01/08/26) at around 10:30 AM. He stated he was covering for another Hospice CNA who was on leave. Hospice CNA stated he provided Resident #10 with a bed bath and basic day to day care. He stated when he provided Resident #10's bed bath he did not observe any dressing on the resident sacrum. Interview on 01/08/2026 at 2:47PM, CNA G revealed he was the CNA assigned to 700 Hall; however, CNA H was the CNA assigned to Resident #10. CNA G stated Resident #10 Hospice CNA never mentioned anything about the resident wound dressing. Attempted to interview CNA H who was assigned to Resident #10 on 01/08/2026 at 3:04 PM and then at 3:06 PM by phone; however, there was no answer. Interview on 01/08/26 at 3:16 PM, LVN C revealed she was the nurse assigned to Resident #10. She stated CNA H nor Hospice CNA report to her regarding Resident #10's wound dressing coming off. She stated if a wound dressing comes off it was expected for the CNAs to inform her, and she could redress it. She stated the risk of not having a dressing could lead to an infection. Interview on 01/08/26 at 4:24 PM, ADON A revealed if a wound dressing comes off it was expected for the CNAs or Hospice CNAs to notify the nurse, and the nurses were to apply a new dressing. She stated if a dressing comes off, (continued on next page)		

Department of Health & Human Services
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they had PRN treatment orders to follow. She stated she was not aware of Resident #10 not having a wound dressing on. ADON A stated the potential risk if the dressing comes off would be infections. Interview on 01/08/26 at 5:17 PM, the DON revealed if a wound dressing comes off when completing care, the CNAs were to notify the nurse, and the nurses were to redress it. She stated the risk of not having a dressing could lead to an infection or possibility of wound deteriorating. Record review of facility Wound Care policy, received October 2010, reflected the following: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 #10 and Resident #104) records reviewed for treatment documentation. The facility failed to document wound care treatments on the Treatment Administration Record for Resident #10 and Resident #104 indicated by blanks on residents January 2026 TAR. These failures could affect the residents medical record not being an accurate representation of the resident's medical condition or medical needs. Findings included: 1. Record review of Resident #10's quarterly MDS assessment, dated 11/20/25, reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. The residents' diagnoses included Alzheimer's Disease (brain condition that slowly damages your memory, thinking, learning and organizing skills), pressure ulcer of sacral region, and chronic obstructive pulmonary disease (a progressive lung condition causing airflow blockage and breathing difficulties), and anxiety disorder (involve more than occasional worry or fear). Resident #10's BIMS score was 04 which indicated severe cognitive impairment. Record review of Resident #10's care plan, revised date 01/04/26, reflected: Focus: The resident has a Stage III pressure ulcer to Sacrum. Goal: The resident's pressure ulcer will show signs of healing and remain free from infection by/through review date. Interventions: Administer treatments as ordered and monitor for effectiveness. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Treatment to pressure ulcer per physician's order. Focus: Wound Management. Goal: Wound will be free of signs or symptoms of infection. Wound will show signs of improvement. Interventions: Provide wound care per treatment order. Record review of Resident #10's physician order dated 01/04/26 reflected Wound Treatment - Collagen and Calcium Alginate w/ Silver every day shift Cleanse wound to Sacrum with Normal Saline or Skin Cleanser. Pat Dry. Apply Collagen to wound bed/tunneling, then Calcium Alginate w/ Silver to wound bed. Cover with Dry Dressing. Start Date 01/05/26. Record review of Resident #10's TAR for January 2025 reflected there was no documentation showing that wound care was provided on 01/05/26 and 01/06/26. Observation and interview on 01/06/2026 at 11:52 AM, Resident #10 was observed in her room lying down in bed. Resident #10 stated she was doing well. Resident #10 stated she admitted with a wound on her bottom, in which she was provided with wound care daily. She stated staff come in to turn her side to side. Observed pressure relieving devices on resident bed. 2. Record review of Resident #104's quarterly MDS assessment, dated 11/20/25, reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. The residents' diagnoses included unspecified dementia (loss of memory, language, problem-solving and other thinking abilities), generalized edema (swelling from excess fluid buildup), and hyperlipidemia (fats in blood). Resident #104's BIMS score was 09 which indicated moderate cognitive impairment. Record review of Resident #104's care plan, revised date 12/22/25, reflected: Focus: [NAME] has current skin concerns: Right Medial foot r/t Surgical Wound by Podiatry. Goal: Areas will heal without complications over the next 90 days. Interventions: Perform treatments per order, if no improvement x2 weeks report to MD. Treatment as ordered. Record review of Resident #104's physician order, reflected Apply foam dressing to R foot lesion medial side. Start Date 12/20/25. Record review of Resident #104's TAR for January 2025 reflected there was no documentation showing that treatment was provided on 01/05/26. Interview on 01/06/2026 at 3:26 PM, Resident #104 was observed in her wheelchair in her room. Resident #104 stated she had no open wounds; however, she had something on her right foot that she was getting treatment for. Resident #104 stated she received treatment every other day. Interview on 01/08/26 at 12:41 PM, Treatment Nurse revealed she had been out on leave and returned to work on 01/07/25. She stated it was the responsibility of the nurses to provide wound care when she was on leave. She (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated once wound care was completed nurses should document that wound care was provided. Treatment Nurse stated if the resident TAR had blanks it could be that treatment was not provided or the nurse forgot to document. Interview on 01/08/26 at 5:20 PM, the DON revealed if the Treatment Nurse was not available to provide wound care, it was the responsibility of the nurses to complete wound care. The DON stated ADON B provided wound care on the days that the Treatment Nurse was on leave. She stated the ADON completed the wound care/treatments but forgot to sign them off on the TAR. The DON stated if the TAR had blanks it would mean that the nurse forgot to document. She stated she expects for her nurses to document or sign the TAR once treatment was completed. The DON stated there was no potential risk as long as the treatment was provided. Interview on 01/08/26 at 5:29 PM, ADON B stated she completed wound on Resident #10 and Resident #104 on 01/05/26. She stated the Treatment Nurse was out on leave and she provided wound care to residents while she was gone. ADON B stated she could not recall if she documented in the residents TAR. She stated if the TAR was blank meant she failed to document the treatment as completed. She stated the potential risk of not documenting accordingly would be that staff not knowing if treatment was done based on documentation and lack of continuity of care. Record review of facility Wound Care policy, received October 2010, reflected the following: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Documentation The following information should be recorded in the resident's medical record: .2. The date and time the wound care was given. 10. The signature and title of the person recording the data.		

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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** 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 1 of 6 residents (Resident #8) reviewed for infection control. LNV C failed to put on appropriate PPE, a gown, before administering daily water flush via gastrostomy tube to Resident #8, who was on enhanced barrier precautions. This failure could place residents at risk of cross contamination and the spread of infection. Findings included: Record review of Resident #8's significant change in status MDS assessment, dated 10/22/25, reflected she was a [AGE] year-old female who admitted to the facility on [DATE]. The resident had a diagnosis of gastrostomy status (surgical opening into the stomach for nutritional support). Resident #8's BIMS score was 07 which indicated severe cognitive impairment. Record review of Resident #8's care plan, revised date 12/06/2025, reflected: Focus: [Resident #8] has a tube feeding r/t poor appetite. The tube is flushed with water TID. Goal: The resident will be free of aspiration through the review date. Interventions: Provide care to G-Tube site as ordered and monitor for s/sx of infection. Record review of Resident #8's physician order dated 12/18/2025, reflected: Enhanced Barrier Precautions every shift Follow Facility Policy - **USE for patients with any of the following (when Contact Precautions do not otherwise apply): Wounds or indwelling medical devices, regardless of MDRO colonization. Observation on 01/08/26 at 8:41 AM revealed LVN C prepared to provide Resident #8's water flush. Resident #8's door had the following sign: Stop, Enhanced Barrier Precautions - Everyone Must - Clean their hands, including before entering and when leaving the room. Providers and Staff Must Also: Wear gloves and gown for the following High Contact Resident Care Activities. Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Observed a bin inside the resident room with gowns. LVN C performed hand hygiene and donned a pair of gloves. Without donning a gown, LVN C then provided Resident #8's 250 ml water flush via gastrostomy tube. Interview on 01/08/26 at 9:17 AM with LVN C revealed she was the nurse assigned to Resident #8. She stated residents who had catheters, g-tubes, IVs or infections were on enhanced barrier precautions. She stated Resident #8 was on enhanced barrier precautions because the resident had a g-tube. LVN C stated residents on enhanced barrier precautions staff should don gloves, and gown. She stated she did not don a gown because she only provided Resident #8 with his water flush. LVN C stated she did not have to don gown for that only gloves. She stated she had been in-service on infection control but could not recall the exact date. LVN C stated there was no potential risk for no donning gown. Interview on 01/08/26 at 9:22 AM with ADON A revealed residents with g-tube, colostomy, wounds, and IVs were on enhanced barrier precautions. She stated staff should don gown and gloves when providing care to the residents. ADON A stated nurses should don gown and gloves when flushing g-tube. She stated staff had been in-serviced on infection control recently but could not recall the date. ADON A stated the potential risk would be infection control. Interview on 01/08/26 at 5:13 PM with the DON revealed residents placed on enhance barrier precaution nurses were expected to don gown and gloves when providing direct care. She stated flushing a g-tube was considered direct care and nurses should don gown and gloves. The DON stated she could not recall when the last in-service was on infection control was completed. She stated there was always a potential risk for not donning appropriate PPE. Record review of facility In-service Training Report, dated 06/27/25, reflected all staff were in-serviced on the following topic: Infection Control - Proper hand hygiene; PPE - donning - putting on isolation gown; doffing - taking of isolation gown. Record review of the facility's Enhanced Barrier Precautions policy, dated March 2024, reflected the following: Policy: Enhanced Barrier Precautions (EBP) is an infection control intervention to reduce transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities. 2. EBP will be used when (continued on next page)		

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Form Approved OMB
No. 0938-0391

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	performing the following high contact resident care activities: Device care or use: central line, urinary catheter, feeding tube, tracheostomy.		