

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/30/2024
NAME OF PROVIDER OR SUPPLIER  San Remo		STREET ADDRESS, CITY, STATE, ZIP CODE 3550 N Shiloh Rd Richardson, TX 75082	

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</b></p> <p>Based on interview and record review the facility failed to ensure residents had the right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely for one of four residents (Resident #1) reviewed for resident rights.</p> <p>The facility failed to ensure Resident #1's room was clean.</p> <p>This failure could place residents at risk for unsanitary living conditions.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet, printed 01/30/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included encephalopathy (brain dysfunction) , hyperlipidemia (high cholesterol), type 2 diabetes (problem in the way the body regulates sugar) and dementia (impaired ability to think, remember or make decisions).</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 01/10/2024, reflected a BIMS score of 12 out of 15, which indicated moderately impaired cognition.</p> <p>Record review of Resident #1's care plan, dated 01/30/2024, reflected ADL function supervision times 1. Goals indicated Resident #1 would maintain a sense of dignity by being clean, dry, odor free and well groomed. Interventions included encourage independence, praise when attempts made, assist with ADL as needed.</p> <p>In an observation and interview on 01/30/2024 at 11:50 AM revealed Resident #1 had a brief on the floor with feces in it. Resident #1 stated he changed his own brief and attempted to throw it in the trash, however, he missed the trash. Resident #1 stated he had not called staff in the room to clean up.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an observation and interview with Resident #1's Family Member on 01/30/2024 at 12:10 PM revealed she visited Resident #1 several times a week and Resident #1's room needed to be cleaned often. Observation revealed Resident #1's family member picked up broken pieces of a thick plastic cup that she stated was from last week that were still on the floor on top of the mat next to the resident's bed. The Family Member also picked up used gauzed and pointed out a brown substance and stated it was feces from the resident changing his own brief. The Family Member stated Resident #1's room frequently had trash on the floor. The family member stated she frequently informed staff that Resident#1's room needed to be cleaned.</p> <p>Interview on 01/30/2024 at 4:14 PM the Housekeeping Supervisor revealed resident rooms were cleaned once a day or more if needed. The Housekeeping Supervisor stated Resident #1's room was one of the rooms that was cleaned more frequently due to the resident having behaviors of throwing things and issues with feces being on the floor. The Housekeeping supervisor stated CNA's or nurses would inform housekeeping staff if additional cleaning was needed.</p> <p>Record review of the facility's policy Resident rights, dated revised February 2021, reflected Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence, be treated with respect, kindness, and dignity.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</b></p> <p>Based on observation, interview, and record review the facility failed to ensure comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for one of three residents (Resident #1) reviewed for care plans.</p> <p>The facility failed to develop a care plan to address Resident #1 wanted to be independent and change his own brief</p> <p>This failure could place residents at risk for receiving delayed treatment and not obtaining/maintaining their highest practicable wellbeing.</p> <p>Findings include:</p> <p>Record review of Resident #1's face sheet, printed 01/30/2024, reflected a was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included encephalopathy (brain dysfunction) , hyperlipidemia (high cholesterol), type 2 diabetes (problem in the way the body regulates sugar) and dementia (impaired ability to think, remember or make decisions).</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 01/10/2024, reflected a BIMS score of 12 out of 15, which indicated moderately impaired cognition. Review of section H bladder / bowel was not completed.</p> <p>Record review of Resident #1's care plan, dated 01/30/2024, reflected ADL function supervision times 1. Goals indicated Resident #1 would maintain a sense of dignity by being clean, dry, odor free and well groomed. Interventions included encourage independence, praise when attempts made, assist with ADL as needed.</p> <p>In an observation and interview on 01/30/2024 at 11:50 AM with Resident #1 revealed a brief on the floor on the side of the bed that was full of feces. Resident #1 was observed to have feces smeared down his leg. Resident #1 stated he had changed his own brief and would do so due to wanting to be as independent as possible. Resident #1 stated he was able to change his own brief however he did usually get feces all over his hands. Resident #1 stated he had not called staff to assist him.</p> <p>In an interview with Resident #1's family member on 01/30/2024 at 12:10 PM revealed she was at the facility several times a week and Resident #1 should not have been changing his own brief due to him getting feces all over himself and the bed rails. The Family Member stated staff should be assisting Resident #1 with changing his brief.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 01/30/2024 at 1:10 PM, CNA A stated Resident #1 had been attempting to change his own brief for a couple of weeks. She stated Resident #1 would not call for assistance stating he wanted to be independent. CNA A stated Resident #1 did need to be cleaned up after he attempted to change his own brief, however, would not call for assistance and would wait until staff were doing rounds to be cleaned. CNA A stated she had informed the nurse working the hall Resident #1 had continued to attempt to change his own brief.</p> <p>In an interview on 01/30/2024 at 1:20 PM, LVN B stated she was the nurse for Resident #1's hall. She stated Resident #1 attempted to change his own brief and staff would promote independence. She stated during rounds the aides would assist Resident #1 with cleaning himself if needed. She stated Resident #1's family member was concerned about him being clean therefore staff tried to make more frequent rounds to ensure he was cleaned.</p> <p>In an interview on 01/30/2024 at 3:00 PM with the Director Nursing revealed Resident #1 believed he was more independent than he was. The Director of Nursing stated Resident #1's family member wanted the facility to be responsible for changing Resident#1's brief, however, Resident #1 wanted to continue doing it himself. The Director of Nursing stated Resident #1 would not use his call light most of the time due to wanting to be independent. The Director of Nursing stated currently staff were responsible for changing Resident #1's brief. The Director of Nursing stated Resident #1's care plan should have included his desire to change his own brief. The Director of Nursing stated she was responsible for ensuring Resident#1's needs were accurately documented on the care plan. The Director of Nursing stated the risk of not having the plan updated would be staff would not know the appropriate care.</p> <p>Record review of the facility's policy Using the care plan, revised August 2008, reflected The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. CNAs are responsible for reporting to the Nurse Supervisor any change in the resident's condition and care plan goals and objectives that have not been met or expected outcomes that have not been achieved. Other facility staff noting a change in the resident's condition must also report those changes to the Nurse Supervisor and/or the MDS Assessment Coordinator. Changes in the resident's condition must be reported to the MDS Assessment Coordinator so that a review of the resident's assessment and care plan can be made.</p>		