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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Discovery Village at Southlake	201 Watermere Drive Southlake, TX 76092

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 48520 Based on observation, interview, and record review, the facility failed to ensure each resident had a right to secure and confidential personal and medical records for 1 (back hallway) of 2 hallways reviewed for privacy and confidentiality. The facility failed to ensure private and confidential clinical records were not left in the back hallway unattended. This deficient practice could place residents at-risk for lack of privacy and confidentiality. The findings included: Continuous observation on 03/14/24 from 11:18 AM to 11:32 AM revealed 3 pages of clinical records titled Midnight Census Report dated 03/13/24. Noted on the printed documents were visible first and last names of residents, room numbers, care levels, and primary payer information. The documents were visible, face up, on a clip board, on top of a bedside table left in the open back hallway near resident's rooms. The bedside table contained menus as well. The documents appeared to have been left by someone who might have entered one of the residents' rooms in the back hallway. Upon entry into the residents' rooms close to where the documents were left, it was revealed no staff member was there. At 11:32 AM the interim Administrator, the DON, and LVN C came to the back hallway and said they were there to remove the unattended visible residents' documents. DON said CNA E might have left the documents there. Interview with CNA E on 03/14/24 at 11:38 AM revealed she was gone for about 10 to 15 minutes and was not aware that she had left resident's information face up. She said she had gone to answer a resident's call light. She said she was making rounds to help residents complete meal choices for Friday, Saturday, and Sunday. She said that she used the midnight census to assist residents fill their meal tickets then she would cross their names off the list. CNA E said she usually took the documents with her if she had to step away, but this time, she rushed to assist a resident. She said that she was trained in protecting residents' information and HIPAA. She said the risk of not securing clinical records was violation of residents' rights. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with DON on 03/14/24 at 04: 51 PM reveled that She had been trained on HIPAA to protect resident information and privacy. She said every staff member is trained on HIPAA. She said she expected CNA E to flip over the clip board with pieces of paper with residents' information or best practice to take document with her. She said she expected everyone to protect resident's records. DON said that she would start in-services immediately. Interview with interim administrator on 03/14/24 at 05:32 PM, revealed he expected all staff to handle clinical records with confidentiality. He said he expected staff to close, turn off, or lock computer screens when not in use. He said all staff are taught to protect resident information when they are hired. He said if a document/s are on paper he expected staff to take it with them and to secure it. He said it was the staff's responsibility to make sure documents are secure. Risk of not securing clinical documents was Breach of resident's privacy. Review of the facility's policy titled Confidentiality of Information and Personal Privacy revised April 2017 revealed: .the facility will safeguard the personal privacy and confidentiality of all resident personal and medical records

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observations, interviews, and record review the facility failed to ensure residents who were incontinent of bowel and bladder received appropriate treatment and services to prevent urinary tract infections and restore as much bowel functions as possible for 1 of 1 (Resident #127) residents reviewed for bowel and blader incontinence. Facility failed to obtain physician orders for Resident #130's suprapubic indwelling catheter, catheter care, and maintenance (A suprapubic catheter is surgically implanted between the urinary bladder and the skin used to drain urine from the bladder). This failure could place residents at risk of infection. Findings included: Review of Resident #130's Admission Records dated 03/13/24 revealed an [AGE] year-old female who admitted to facility on 03/01/24 with diagnoses including pressure ulcer (injury to skin and tissue due to pressure) of sacral region and paraplegia (paralysis in lower half of body). Review of Resident #130's order summary dated 03/13/24 did not reflect physician orders for suprapubic indwelling catheter, catheter care, and maintenance. Observation and interview on 03/13/2024 at 09:40 AM, revealed Resident #130 had a suprapubic indwelling catheter, LVN C stated Resident #130 had home health and they were changing the catheter, and she could not remember the last time it was replaced. Interview on 03/13/2024 at 09:57 AM, the DON stated she would check with the nurse about the last time the foley was changed. She said there should be orders for the suprapubic indwelling catheter. DON did respond risk to resident for not having an order for care, maintenance of supra pubic catheter. Interview on 03/13/2024 at 10:00 AM, RN G stated the orders should come from urologist or the place of admission when the resident admits. She stated nursing should enter the orders. RN G stated she did catheter care which included assessing the color and amount and charted in the progress notes. Interview on 03/13/2024 at 11:31 AM, the DON stated she will change the catheter today, updated the care plan and inputting orders. She said Resident #130 should have orders and the admitting nurse should have put orders in. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/13/2024 at 12:06 PM, the Attending Physician stated Resident #130 was her long-term patient and was aware she had a catheter. She stated the hospital should have given a date and home health would contact the office with the date of when it was changed. She said staff know they were supposed to look at the hospital records and should transcribe the orders. She said staff will review medications with the doctor, review records and talk to the family. She stated the DON and ADON double check orders. Interview on 03/14/2024 at 03:40 PM, the Administrator stated his expectation was every order to be put in and every nurse was trained to make sure that all physician orders go in. He stated the nurse was responsible and the DON should make sure all orders were in. He stated as the Administrator he was responsible to ensure that the policies were followed. The Administrator stated in IDT meetings, they go over orders including medications and diets. Interview on 03/14/2024 at 06:04 PM, the Interim Administrator stated his expectation was all residents should have orders. He stated physician orders drive care and instructs the care provider what to do. Record review of facility policy titled, Medication Orders revised 2014, reflected Supervision by a Physician 1. Each resident must be under the care of a Licensed Physician .2. A current list of orders must be maintained in the clinical record of each resident. 3. Orders must be written and maintained in chronological order .6. Treatment orders - When recording treatment orders, specify the treatment, frequency and duration of the treatment .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review the facility failed to ensure that residents who need respiratory care are provided with such care, consistent with professional standards of practices for 1 of 2 residents (Resident #127) reviewed for respiratory care. Facility failed to obtain physician orders for Resident #127 to use, care, and maintain a CPAP machine. A CPAP machine is Continuous Positive Airways Pressure machine to keep breathing airways open while sleeping. These failures could place residents who receive respiratory care at risk of developing infections and a decreased quality of care. Findings Included: Review of Resident #127's Admission Record dated 03/13/24 reflected an [AGE] year old female admitted to facility on 03/05/24 with diagnoses that included Asthma (a condition in which the airway becomes inflamed, narrowed and swells), chronic obstructive pulmonary disease/COPD (a group of lung disease that block airflow and make it difficult to breath), Sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts), unilateral primary osteoarthritis of left knee (a chronic condition affecting the knee joint), and left artificial knee joint (total left knee replacement). Review of Resident #127's MDS assessment dated [DATE] did not reflect a BIMs score or CPAP oxygen use when sleeping. Review of Resident #127's hospital discharge date d 03/04/24 reflected reactive airway disease, sleep apnea, asthma and COPD were on Resident #127's problem list. It also reflected that Resident #127 was alert and oriented X 4, indicating she was cognitively intact and could understand others and others could understand her. Review of Resident #127's order summary dated 03/13/24 did not reflect physician orders for use of CPAP machine when asleep. Observation and interview with Resident #127 on 03/12/2024 at 10:12 AM revealed she admitted with a CPAP machine to the facility. She said that family had brought the water needed to use the machine. She said that she used the machine at home and had been using it at facility since admission 03/05/24. Interview on 03/14/2024 at 04:54 PM, the DON stated she was not aware Resident #127 had a CPAP. She said nurses were in charge of doing admissions and the DON and IDT will follow up with medications, physician orders, immunization and consents. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/14/2024 at 03:40 PM, the Administrator stated his expectation was every order to be put in and every nurse was trained to make sure that all physician orders go in. He stated the nurse was responsible and the DON should make sure all orders were in. He stated as the Administrator he was responsible to ensure that the policies were followed. The Administrator stated in IDT meetings, they go over orders including medications and diets. Interview on 03/14/2024 at 06:04 PM, the Interim Administrator stated his expectation was all residents should have orders. He stated physician orders drive care and instructs the care provider what to do. Record review of facility policy titled, Medication Orders revised 2014, reflected Supervision by a Physician 1. Each resident must be under the care of a Licensed Physician .2. A current list of orders must be maintained in the clinical record of each resident. 3. Orders must be written and maintained in chronological order .6. Treatment orders - When recording treatment orders, specify the treatment, frequency and duration of the treatment .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review, the facility failed to assess the residents for risk of entrapment from bed rails prior to installation, review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation of bed rails for 1 of 3 residents (Resident 11) reviewed for bed rails. The facility failed to ensure physician orders were written for bed rail use for Resident #11. This failure could place residents at risk of injury. Findings Included: 1. Review of Resident #11's Admission Records dated 03/13/24 revealed an [AGE] year-old female who admitted to facility on 03/15/23. Her diagnoses included senile degeneration of brain (a condition that causes a significant cognitive decline in abilities, memory, and language), muscle weakness, abnormalities of gait and mobility, repeated falls, depression, arthritis (a degenerative joint disease), difficulty in walking, high cholesterol, high blood pressure, altered mental status (a condition characterized by confusion, disorientation, and disorder) and lack of coordination. Review of Resident #11's MDS assessment dated [DATE] revealed a BIMS score of 1, indicating she had severe cognitive impairment and memory issues. Review of section P of MDS did not indicate bed rail use for Resident #11. Review of Resident #11's Care plan with an effective date of 03/11/24 reflected the following: Focus: My Bed Mobility Self Care Performance is independent. Goal: staff will assist me with my bed mobility on a daily basis over the next 90 days (Revision 8/15/23, target date 02/07/24). Interventions: I am independent with bed mobility. No revision date to indicate need for bed rail use. Care plan also reflected: o Focus: I have elected [hospice provider] hospice services r/t terminal diagnosis: Senile Degeneration of the brain Date Initiated: 01/25/2024. Goal: Dignity will be maintained, and the resident will be kept comfortable and pain free within one hour of intervention over the next 90 days. My comfort needs will be met over the next 90 days by adding hospice caregivers to my care. Date Initiated: 01/25/2024. Interventions: Administer comfort Medications as indicated by MD/Hospice, Administer Oxygen as indicated, Assist me with meals and hydration if I am unable to help myself, Assist with ADLs and provide comfort measures as needed, Delineation of Task for [hospice provider] Hospice Services to provide: Hospice will provide disease related medications according to POC as listed on hospice medication list, Hospice will assist with teaching facility staff, resident and family regarding death/dying, pain management, pain interventions/medications for symptom control. Hospice Pharmacy to review medications every 15 days and make recommendation based on the review as needed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #11's order summary dated 03/13/24 did not reflect physician orders for use of bed rail. Observation and interview on 03/14/2024 at 2:04 pm revealed Resident #11's left bed rail raised. CNA D stated she was told to only raise rail on one side of the bed; she stated the right rail was broken and hospice was aware. Interview and record review on 03/14/2024 at 10:59 AM, LVN B stated they usually raise the left bed rail to help Resident #11 not fall out of bed. She stated she did not know if the resident had orders for bed rails. LVN B looked in the MAR and hospice book and found no orders for bed rails. LVN B stated Resident #11 was on hospice and that was the bed hospice provided. She said she was not sure of the policy on using bed rails. LVN B stated having both rails up was a form of restraint if the resident could not get out of bed. Interview on 03/14/2024 at 11:27 AM, LVN B stated the MDS Coordinator said this was a restraint free facility and LVN B was asked to remove the rails from Resident #11's bed and she alert hospice. Interview on 03/14/2024 at 05:19 PM, the MDS Coordinator stated they were a restraint free facility and rails up would be a restraint. She stated she had no idea that Resident #11 had a bed with rails. Interview on 03/14/2024 at 03:40 PM, the Administrator stated his expectation was every order to be put in and every nurse was trained to make sure that all physician orders go in. He stated the nurse was responsible and the DON should make sure all orders were in. He stated as the Administrator he was responsible to ensure that the policies were followed. The Administrator stated in IDT meetings, they go over orders including medications and diets. Interview on 03/14/2024 at 06:04 PM, the Interim Administrator stated his expectation was all residents should have orders. He stated physician orders drive care and instructs the care provider what to do. Record review of facility policy titled, Bed Safety revised 2007, reflected .5. If side rails are used, there shall be an interdisciplinary assessment of the resident, consultation with the Attending Physician, and input from the resident and/or legal representative. 6. The staff shall obtain consent for the use of side rails from the resident or the resident's legal representative prior to their use. 7. After appropriate review and consent as specified above, side rails may be used at the president's request to increase the resident's sense of security. 8. Side rails may be used if assessment and consultation with the Attending Physician has determined that they are needed to help manage a medical symptom or condition, or to help the resident reposition or move in bed and transfer, and no other reasonable alternatives can be identified .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45507 Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation and storage. The facility failed to ensure the thermometer used in the refrigerator read the accurate temperature. This failure could place residents at risk of foodborne illness. Findings included: Observation and interview on 03/12/2024 at 8:59 AM revealed the thermometer hanging on one of the shelves inside of the refrigerator read 50 degrees F. The Assistant Dietary Manager read the thermometer at 50 degrees F and stated she could put another thermometer inside. She said the temperature should be 41 degrees or below. She said the built-in thermometer on the outside of the refrigerator read 37 degrees F. Observation on 03/13/2024 at 11:55 AM revealed a different thermometer inside the refrigerator that read 36 degrees F. Interview on 03/14/2024 at 11:47 AM the Dietary Manager stated she or the cook was responsible to verify the temperature was correct. She stated the thermometer inside was just a backup and she did not think she would have a thermometer inside the fridge after this. Interview on 03/14/2024 at 3:56 PM, the Administrator stated his expectation was for food to be kept at the proper temperature. He stated they go by the thermometer that was inbuilt and that was the accurate one. Record review of facility policy titled, Refrigerators and Freezers revised December 2014, revealed: This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation .

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 45507 Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly for 1 out of 1 kitchen observed. The facility failed to have a garbage can near the handwashing sink. The facility failed to ensure garbage cans with lids were used in the kitchen. This failure could place residents at risk for foodborne illness. Findings included: Observation and interview on 03/12/2024 at 8:59 AM, revealed there was no trash can with a lid near the handwashing sink. The Assistant Dietary Manager stated they had a step trash can, but it was broken, and another one was supposed to be in today. She moved a garbage can without a lid (that was not in use) from the food prep area and put it near the sink. She stated the garbage can was supposed to have a lid for cross contamination. Interview on 03/14/2024 at approximately 11:47 am, the Dietary Manager stated she got three step trash cans with lids and placed them in the kitchen. Interview on 03/14/2024 at 5:42 PM, the Interim Administrator stated the reason for a step trash can was to ensure staff did not touch anything. He stated the garbage cans should have lids so that anything in the air will not be circulating. The facility did not provide a policy on garbage and refuse in the kitchen. Record review of the US FDA Food Code, dated 2022, reflected: 5-501.113 Covering Receptacles. Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered: (A) Inside the FOOD ESTABLISHMENT if the receptacles and units: (1) Contain FOOD residue and are not in continuous use; or (2) After they are filled; and (B) With tight-fitting lids or doors if kept outside the FOOD ESTABLISHMENT .

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 48520 Based on interview and record review, the facility failed to electronically submit to CMS complete and accurate direct care staffing information for quarter review for Fiscal year Quarter 1 of 2024 (October 1- December 31, 2023). The facility failed to submit RN staff hours for 11/12/23, 12/02/23, 12/03/23, 12/17/23, 12/24/23, and 12/30/23. Findings included: Review of the CMS PBJ report for Fiscal Year Quarter 1 of 2024 (October 1- December 31, 2023) reflected No RN Hours was triggered, for lack of RN coverage on 11/12/23, 12/02/23, 12/03/23, 12/17/23, 12/24/23, and 12/30/23. Review of RN time stamp detail sheets for DON and direct care schedules for 11/12/23, 12/02/23, 12/03/23, 12/17/23, 12/24/23, and 12/30/23 reflected sufficient RN coverage on those dates. An interview with DON on 03/13/24 at 03:45 PM revealed that she was responsible for scheduling the nurses. She said that if there was no RN on duty for the day, she would come into work. DON provided RN hours on 11/12/23, 12/02/23, 12/03/23, 12/17/23, 12/24/23, and 12/30/23. She said that because she was a salaried employee, it was not possible to clock in and clock out therefore, she wrote the time and date on the schedule, signed it, and turned them in to the Administer. An interview with interim Administrator on 03/13/24 at 04:06 PM revealed DON is mandated to work 8 hours if there was no nurse on the schedule. He said she does not clock in using a tracking tool. She writes her ins and outs with signature. An interview with the Administrator on 03/14/24 at 04:06 PM revealed that because his parent company was not a typical nursing home company, all department heads were salaried employees. He said his system was not set up to report DON hours worked for 11/12/23, 12/02/23, 12/03/23, 12/17/23, 12/24/23, and 12/30/23. He said that he used a third-party HR vendor payroll company that sent him a document with all hours of employees that clock in and clock out. He said he was unable to edit the information to add the missing RN hours because it altered the format of the document and PBJ website would not accept the altered file. He said that he had reached out to PBJ website, but they told him They could not help him. Facility did not provide policy for PBJ staffing data reporting at exit 03/14/24 at 06:50 PM. Review of CMS undated policy PROCEDURE AND GUIDANCE S483.35(b) reflected The facility is responsible for submitting staffing data through the PBJ (Refer to, S483.70(q)).