STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676405	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forum Parkway Health & Rehabilitation	2112 Forum Parkway Bedford, TX 76021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on observation, interview and record review, the facility failed to provide the necessary services to maintain good grooming for a resident who is unable to carry out activities of daily living for 1 of 3 residents (Resident #14) reviewed for ADL care. The facility failed to ensure Resident #14 received grooming assistance to remove unwanted facial hair. This failure could affect the residents who require assistance with care from facility staff by placing them at risk for social isolation, loss of dignity and self-worth. Findings included: Record review of Resident #14's MDS assessment, dated 11/02/24, reflected the resident was a [AGE] year-old female initially admitted to the facility on [DATE] and most recently admitted on [DATE]. Resident #14 admitted to the facility with diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), heart failure, diabetes mellitus (a group of diseases that result in too much sugar in the blood), aphasia (a language disorder that affects a person's ability to communicate), hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), unspecified dementia (dementia without a specific cause), and cerebrovascular accident (damage to the brain from interruption of its blood supply). Resident #14 also had severe cognitive impairment and required substantial to maximal assistance for personal hygiene. Record review of Resident #14's Comprehensive Care Plan, dated 11/12/24, reflected the resident had an ADL self-care performance deficit related to a condition that left the resident able to use only one side of her body and required staff assistance with personal hygiene. Record review of Resident #14's shower sheet, for date range of 12/15/24 through 01/13/25, reflected resident was showered on 12/17/24, 12/21/24, 12/26/24, 12/31/24, 01/02/25, 01/04/25, 01/07/25, and 01/11/25. Record review of Resident #14's personal hygiene (shaving) sheet, for a date range of 12/15/24 through 01/13/25, reflected resident was not shaved on all dates of the record. Record reflected Resident #14 refused on 12/19/24, 12/24/24, and 01/09/25. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 01/07/25 at 1:34 PM revealed Resident #14 had 10-15 long brown and gray facial hairs approximately 0.5 inches in length on her chin area. Resident #14 stated she wanted her facial hair removed. Resident #14 did not say how it made her feel due to a diagnosis of aphasia, but the resident had a grimace on her face when she was asked about her facial hair. Resident #14 also revealed staff did not ask her if she would like them to shave her facial hair when they showered her, and she did not ask them to shave her. Interview on 01/08/25 at 2:57 PM with CNA A revealed Resident #14's shower days were Tuesdays, Thursdays, and Saturdays. CNA A stated she was responsible for showering Resident #14 on her shift because she was an afternoon shower recipient. CNA A stated she asked residents on their shower days if they would like to be shaved on those days. CNA A said Resident #14 usually refused to be shaved when she asked her. CNA A stated she shaved Resident #14 on 01/07/25 during her shift. Interview on 01/13/25 at 11:10 AM with LVN T revealed residents' facial hair should be shaved at least every three days depending on how fast the hair grew. LVN T stated it was the CNAs responsibility to shower and shave residents. LVN T stated residents were shaved on shower days, which was three days per week. LVN T said CNAs asked residents when they showered them if they would like to be shaved. LVN T revealed it was the charge nurse's responsibility to ensure the residents got shaved. LVN T stated if the residents did not get shaved, the CNA was supposed to inform the charge nurse so that they could assist as well as educate and possibly notify the responsible party of the resident's refusal. LVN T said the importance of residents being free of unwanted facial hair was that it affected the resident's appearance and therefore self-esteem. Interview on 01/13/25 at 11:21 AM with ADON B revealed it was the CNAs responsibility to look at residents' facial hair when showering residents. ADON B stated CNAs should be offering to shave residents on the residents' shower days. ADON B said if a resident refused to be shaved, the nurses were supposed to be notified so they could assist the CNA. ADON B stated nurses should notify the responsible party if the resident refused to be showered and shaved. ADON B also stated the nurse should document the refusal, notification, and notify management. ADON B stated the risk to Resident #14 could be embarrassment by having facial hair. Interview on 01/13/25 at 3:47 PM with the DON revealed it was the CNAs responsibility to ensure residents had unwanted facial hair removed. The DON stated the CNAs should shave residents on the residents' shower days. The DON said if a resident refused, they should document it in the electronic health record and notify their charge nurse. The DON stated it was the nurse's responsibility to notify the responsible party of a residents refusal and to assist the CNA with showering and shaving the resident as well as educating them. The DON stated the risk to the resident was that it was a dignity issue. Record review of the facility's Shaving the Resident policy, revised October 2010, reflected the following: POLICY Statement: The purpose of this procedure is to promote cleanliness and to provide skin care. Documentation (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.5. If the resident refused the treatment, the reason(s) why and intervention taken. 6. The signature and title of the person recording the data. Reporting 1. Notify the supervisor if the resident refuses the procedure. 2. Report other information in accordance with facility policy and professional standards of practice. The policy did not address how often a resident should be shaved.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 44937 Based on interview and record review, the facility failed to ensure a resident with an indwelling urinary catheter received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 3 residents (Resident #9) reviewed for catheter care. The facility failed to follow physician orders for routine catheter care including cleaning for Resident #9. This failure could place residents with foley catheters at risk of urinary infection and improper catheter care. Findings included: Record review of Resident #9's face sheet dated 01/13/25 reflected Resident #9 was a [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #9's quarterly MDS dated [DATE] reflected Resident #9 was cognitively intact with a BIMS score of 13. The MDS indicated Resident #9 required substantial/maximum assistance with toileting, showering/bathing and personal hygiene. The MDS further reflected Resident #9 had an indwelling catheter. Resident #9's diagnosis included debility (weakness), cardiorespiratory conditions (conditions that affect the structure or functions of the heart), Neurogenic bladder (lack of bladder control due to spinal cord, brain injury, or nerve problems), irritable bowel syndrome (condition that affects the stomach and intestines) with diarrhea and cervical disc disorder with myelopathy (condition that is caused by age related changes to the bones, ligaments and discs of the neck). Record review of Resident #9's care plan reflected Resident #9 had an indwelling Foley catheter related to two or more post voiding residual urine volumes greater than 200 cc. The care plan goal was resident will not show signs or symptoms of urinary tract infection. The care plan interventions included changing the catheter as ordered, checking for patency and urinary output every shift, checking the tubing for prints, observing for pain and discomfort due to the catheter, reporting to the physician any signs of urinary tract infection, and positioning the catheter at the lowest position. Record review of Resident #9's physician's orders dated 04/05/23 reflected Resident #9 had orders to irrigate her Foley catheter with 60-100 ml normal saline for occlusion and to change the foley catheter every month and when needed for occlusion. Record review of Resident #9's January 2025 MARs/TARs reflected: Foley catheter care Q shift and PRN every shift Change Foley Catheter PRN for obstruction or if closed system is compromised. Every night shift starting on the 5th and ending on the 5th every month. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Enhanced Barrier Precautions every shift for r/t foley Interview on 01/07/25 at 1:26 PM with Resident #9 revealed she felt she did not get proper care due to her requiring a Hoyer lift. Resident #9 stated she felt staff were not changing her as often. When asked about her catheter care, she stated there were times she felt unclean and irritated near the catheter insertion. Interview on 01/08/25 at 9:14 AM with CNA M revealed she had drained Resident #9's catheter bag that morning. CNA M stated she also checked the resident's brief, and the brief was dry. Observation on 01/08/25 at 9:51 AM revealed CNA M completed incontinence care for Resident #9. The resident's brief was dry, and the resident's skin was intact. CNA M then sanitized, added skin protectant cream to the resident's perineal area, and put a clean brief on the resident. CNA M did not provide the resident with catheter care. Interview on 01/08/25 at 10:08 AM with CNA M revealed she did not complete catheter care. CNA M stated, I should have provided catheter care .I am sorry, I forgot. CNA M stated, I did not clean the middle. I did not hold it and clean the area. I am sorry. I forgot. CNA M stated she was responsible for ensuring she provided proper catheter care during incontinence care so that residents were not placed at risk of infection. Interview on 01/13/25 at 1:48 PM with LVN D revealed she worked with Resident #9 on 6:00 AM-2:00 PM shift. According to LVN D, CNAs were responsible for completing proper catheter care. LVN D stated CNAs should wipe from front to back on all residents and if there was a catheter placed, CNAs should be cleaning the catheter as well. LVN D stated if there were any signs of infection or irritation present staff should alert her. LVN D stated not doing so would place residents with a catheter at risk for infections. Interview on 01/13/25 3:46 PM with the DON revealed CNAs were responsible for completing catheter care. The DON stated he expected CNAs to clean and follow the facility policy when it came to activities of daily living care. He stated not doing so placed residents at risk of infection. Record review of the facility's current Catheter Care, Urinary policy and procedure, revised September 2014, reflected the purpose of the procedure was to prevent urinary catheter-associated urinary tract infections. The policy reflected: .wash the resident's genitalia and perineum thoroughly with soap and water. Rinse the area well and towel dry for a female resident: Use a washcloth with warm water and soap to cleanse the labia. Use one area of the washcloth for each downward, cleansing stroke. Change the position of the washcloth with each downward stroke. Next, change the position of the washcloth and cleanse around the urethral meatus. Do not allow the washcloth to drag on the resident's skin or bed linen. With a clean washcloth, rinse with warm water using the above technique Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards for 1 of 2 residents (Resident #64) reviewed for intravenous fluids. The facility failed to ensure the dressing on Resident #64's peripheral intravenous line (a short flexible tube inserted into a vein to administer fluids and medications) was dated and initialed. The failures could affect residents by placing them at risk for infections. Findings included: Record review of Resident #64's entry MDS assessment, dated 12/27/24, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. The resident had diagnoses which included: urinary tract infection (a bacterial infection that causes inflammation in the urinary tract). Resident #64 had moderate cognition with a BIMS score of 11. She had intravenous access. Record review of Resident #64's physician's orders dated 01/06/25 reflected: May insert peripheral intravenous line for intravenous fluids. Normal Saline Flush Intravenous Solution (Sodium Chloride Flush) Use 2 liter intravenously every shift for Prophylactic fluids. Run at 75cc/hr. till completed). Record review of Resident #64's current care plan initiated 01/07/25 reflected the resident was at risk for fluid deficit rule out intravenous fluids given. The care plan reflected: Goals: Will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor. Interventions: Provide medication per order. Check vital signs as ordered/per protocol and record. Notify MD of significant abnormalities. Observation and interview on 01/07/25 at 12:15 PM revealed Resident #64 was seated in her wheelchair in her room. She had a peripheral intravenous line dressing with no date on her right hand, and the dressing was intact. Resident #64 stated the peripheral line was inserted on 01/06/25. There were no signs or symptoms of infection noted at the peripheral line site. Observation and interview on 01/07/25 at 12:28 PM with LVN H, who was the charge nurse for Resident #64, revealed the resident had a peripheral line in her right arm covered with a transparent dressing with no date. LVN H revealed she hung the intravenous fluid in the morning. She stated she knew she was supposed to check the date on the dressing, the site for infection, and the status of the dressing. She stated she did not check it, and she missed it. She stated by failing to have a dated on the dressing the staff would not know when the dressing needed to be changed, and it could cause infection. She stated she had done training on intravenous medication and fluids administration upon hire. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/08/25 at 1:49 PM with the DON revealed he expected staff to have noted there was no date on the dressing and rectify it. He stated the peripheral line was inserted by their service provider, but it was the facility's responsibility to monitor the line. He expected them to have notified him so that he could have called the provider and notified them to prevent a repeat of the same. He stated it was an oversight on the facility's side. He stated not having the date on the dressing meant they would not know when the insertion was done, when to change the dressing, or discontinue the peripheral line since it was good for 72 hours. He stated they had done training with the staff. Record review of the facility's training record provided reflected training on dressing changes dated 09/19/23, and LVN H was in attendance. Record review of the facility's Peripheral Intravenous Catheter Insertion policy, dated April 2016, reflected the following: .Dressings 1. Use sterile dressing (transparent or gauze, as appropriate) to cover insertion site. 2. Label on dressing should include date and time of dressing placement, initials gauge size and length of the catheter

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice for 1 of 3 residents (Resident #47) reviewed for oxygen. The facility failed to have accurate physician orders for oxygen use for Resident #47. This failure could place residents who received oxygen therapy at risk for inadequate or inappropriate amounts of oxygen delivery and possible infection. Findings included: Record review of Resident #47's Admission Record dated 01/08/25 reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #47's quarterly MDS, dated [DATE], reflected a BIMS score of 15, indicating cognition was intact. The resident's diagnosis included: stroke (poor blood flow to a part of the brain causing cell death), cancer (group of diseases involving abnormal cell growth that can spread to other parts of the body), pneumonia (infection caused by bacteria or virus of the air sacs in one or both lungs), anxiety disorder (group of mental disorder characterized by significant and uncontrollable feelings). His MDS indicated he received oxygen therapy while a resident. Record review of Resident #47's last care plan review completed on 12/23/24 reflected Resident #47 had COPD/Emphysema (an umbrella term given to a group of chronic lung diseases that make it harder to breathe air out of the lungs). The care plan reflected the goal was that the resident would display an optimal breathing pattern daily. The care plan reflected: Interventions: Document/report to physician as needed with signs and symptoms of respiratory infection: fever, chills, increase in sputum (document amount, color, and consistency), chest pain, increased difficulty breathing (Dyspnea), increased coughing and wheezing. Give oxygen therapy as ordered by the physician. Head of bed to be elevated (semi-Fowlers to fowlers) or out of bed upright in a chair. Observe for difficulty breathing (Dyspnea) on exertion, remind resident not to push beyond endurance. Observe for signs and symptoms of acute respiratory insufficiency: Anxiety, Confusion, Restlessness, Short of breath at rest. Observe and document for Anxiety. Record review of Resident #47's progress notes reflected the following entries: - 01/02/25 at 10:34 PM: Resident complaint of trouble breathing and O2 sat 88%/NC on O2 5 L/min and respiratory rate 30 b/m. this nurse notified hospice that the resident having trouble breathing so the nurse replied to increase O2 to 8-10 L/min and administer as needed breathing treatment. Now the resident is administered O2 6 L/min and O2 sat 96% and breathing treatment continued. Hospice nurse notified to send out the comfort kits. Night shift nurse aware and the care is continued. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 01/03/25 at 5:19 AM: Continues with O2 therapy for shortness of breath and O2 increased to 8L per hospice order. Cough noted and cough syrup administered. No complain of pain. Comfort kit delivered. Vital signs Blood Pressure 90/61, Pulse 81, Respiratory 19, Temperature 97.6, O2 sat @ 95% via Nasal Cannula. Head of Bed raised, no distress noted. Call light within reach. Record review of Resident #47's physician orders for oxygen use reflected: Oxygen via NC 2-4 L/min No directions specified for order. Active12/20/2024 O2: O2 at 2L/minute via Nasal Cannula continuously every shift. Active 12/13/24 O2: O2 stats every shift. Active 12/13/24 O2: Change and label water humidification and Nasal Cannula tubing weekly on Sunday and on 10-6 shift. No directions specified for order. Active 12/13/24 Record review did not reveal an active order for Resident #47 to receive oxygen at 8-10 liters per minute. Observation and interview on 01/07/25 at 11:10 AM revealed Resident #47 had been on oxygen and all of a sudden he had issues with breathing. He stated the facility called his doctor, and his oxygen was increased to 8 liters per minute. Resident #47 stated ever since his oxygen was increased it was helpful, and he had not had any further problems breathing. Resident #47 stated he needed to use oxygen at all times. Observation of Resident #47's oxygen level revealed he was receiving 7 liters per minute. Resident #47 did not know why his machine was only showing him receiving 7 liters per minute. Observation on 01/08/25 at 3:10 PM revealed Resident #47 was in bed. The resident was receiving 7 liters per minute of oxygen via nasal cannula. Observation and interview on 01/08/25 at 3:15 PM with RN C revealed Resident #47 was receiving oxygen via nasal cannula. The oxygen machine was running at 7 liters per minute. RN C said Resident #47 had been having a hard time breathing, so she contacted his physician, and received an order to increase his oxygen level to 8-10 liters per minutes. RN C said Resident #47 was receiving 8 liter per minute since 01/02/25. RN C pointed out progress notes which reflected she had documented the occurrence. When asked to provide the physician order, RN C stated she was not able to locate the new order; however, his order for oxygen revealed he was to receive 2-4 liters per minute. RN C further stated 2-4 liters was not working for Resident #47, so she contacted the physician. RN C stated it was her responsibility to enter the new order for oxygen, so everyone was aware of the increase. RN C stated it was the responsibility of the nursing staff to check Resident #47's oxygen levels on every shift. RN C stated she could not explain why Resident #47 was currently receiving 7 liters because he should be receiving at least 8. She stated she did check on the resident upon shift change and may have missed checking his oxygen. RN C stated not entering the new order and not ensuring Resident #47 was being administered the proper oxygen liters per minutes placed him at risk of not receiving the correct level of oxygen for his needs. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/13/25 at 1:48 PM with LVN D revealed she was working with Resident #47 on 01/07/25 and 01/08/25 during the 6:00 AM-2:00 PM shift. LVN D stated Resident #47's oxygen machine should be running at 8-10 liters per minute. LVN D said Resident #47's oxygen was dropping really bad when he was receiving 2-4 units. LVN D stated the nurse on shift at the time contacted the resident's physician to have his oxygen increased to 8 liters per minute, and the resident's breathing became better along with his oxygen levels. LVN D stated she did not verify the order, as she was given the information at shift change and had noticed him breathing better with the change. LVN D stated it was the responsibility of the nurse who received the order to enter the order in the system and notify the family. LVN D stated it was the responsibility of all nurses on each shift to check his oxygen levels and ensure his machine is reading between 8-10 liter per minute. LVN D stated she was aware of his new order and had been implementing the change. LVN D stated, On my shift anytime I do his breathing treatments, I will check and monitor as needed. If the liters were on 7 units, this means he was not getting the proper amounts of oxygen needed. LVN D stated not entering updated orders, following physician orders, and proper monitoring for oxygen levels placed Resident #47 back at risk for further breathing complications. Interview on 01/13/25 at 3:46 PM with the DON revealed he was not aware there were no updated orders regarding Resident #47's oxygen use. The DON stated he expected nurses who received an updated order from physicians to transcribe those orders into the system. The DON stated not doing so placed Resident #47 at risk of not receiving what he required for proper breathing. The DON stated it was important to follow physician orders and nurses should be monitoring on every shift to ensure orders are being followed. Record review of facility's current, undated Telephone Orders policy reflected: .Verbal telephone orders may be accepted from each resident's Attending Physician. 1. Verbal telephone orders may only receive by licensed personnel. Orders must be reduced to writing, by the person receiving the order, and recorded in the resident's medical record. 2. The entry must contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information. 3. Telephone order must be countersigned by the physician during his or her next visit Record review of the facility's Oxygen Administration policy, revised March 2004, reflected the purpose of the procedure was to provide guidelines for safe oxygen administration. The policy reflected that staff were to verify that there was a physician's order for the procedure, and review the physician's orders for facility protocol for oxygen administration.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 2 residents (Resident #48) reviewed for dialysis. The facility failed to ensure dialysis communication forms were completed for Resident #48 before going for dialysis and after returning from dialysis treatment. This failure could place residents at risk of inadequate communication between the facility and dialysis center. Findings included: Record review of Resident #48's admission MDS assessment, dated 11/25/24, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #48 had a diagnosis of chronic kidney disease (a chronic condition that occurs when the kidneys can no longer filter waste from the blood and requires long-term dialysis or a kidney transplant to maintain life). She had a BIMS score of 14, which indicated her cognition was intact. The MDS reflected Resident #48 received dialysis. Record review of Resident #48's care plan, dated 09/24/24, reflected Resident #48 needed hemodialysis (medical procedure that filters blood to remove waste and extra fluid when the kidneys are no longer functioning properly). The goals for this care plan reflected that Resident #48 would have no signs of complication from dialysis through next review, obtain vital signs and weight per protocol, and staff will report significant changes in pulse, respirations, and blood pressure immediately. Record review of Resident #48's January 2025 physician's order reflected orders to obtain and document vital signs prior to Resident #48 left for dialysis and upon return from dialysis. Record review of Resident #48's EHR reflected there was nursing documentation regarding Resident #48's pre- and post-dialysis vital signs, but the documentation was missing any communication from dialysis center. Record review of Resident #48's dialysis communication forms from 11/21/24 to 01/13/25 reflected dialysis communication form for December 2024 dated 12/02/24 all the other dialysis dates of the month of November 2024, December 2024 and January 2025 were missing communication forms totaling to: 4 days in November 2024: 11/22/24, 11/25/24, 11/27/24, and 11/29/24; 12 days in December 2024: 12/04/24, 12/06/24, 12/09/24, 12/11/24, 12/13/24, 12/16/24, 12/18/24, 12/20/24, 12/23/24, 12/27/24 and 12/30/24; and 4 days in January 2025: 01/03/25, 01/06/25, 01/08/25 and 01/10/25. (continued on next page)

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Forum Parkway Health & Rehabilitation	2112 Forum Parkway Bedford, TX 76021

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/07/25 at 11:38 AM with Resident #48 revealed she went for dialysis on Monday, Wednesday, and Friday. She stated she got a form that she took to dialysis and brought back to facility. Interview on 10/11/24 at 1:04 PM with LVN E revealed she was aware she was supposed to send Resident #48 with the dialysis communication form when she left for dialysis and then collect the form when the resident returned from dialysis. LVN E stated she knew she was supposed to monitor the dialysis access site for the bruit thrill (a vibration caused by blood flowing through the fistula and can be felt by placing fingers just above incision line), dressing for bleeding and vital signs when Resident #48 was back from dialysis. She stated it was all nurse's responsibility to update the dialysis communication form when Resident#48 came back and filed them. LVN E stated they were supposed to call the dialysis clinic, but she stated the resident came back during the evening shift. She checked the file and there were no Resident #48 communication forms filed. She stated failure to follow-up on the communication form after dialysis was they could miss orders and recommendations from the dialysis center. She stated she had not done training on the dialysis communication form. Interview on 01/13/25 at 1:49 PM with the ADON F revealed the nurses were supposed to fill the form with pre-dialysis vitals, and the form was supposed to be taken to dialysis by Resident#48. He stated he expected the nurses to collect the form after dialysis, perform vital signs, and document on the communication form and in the electronic health record. He stated the importance of the communication form was communication between the facility and the dialysis center regarding new orders, treatments given, and any change of condition. He stated he had checked the binders and had noticed the communication forms were missing, but he could not tell when he last checked the dialysis binder. He stated he was responsible for ensuring nurses were completing the forms. He stated all nurses were aware they were supposed to fill out and collect the forms, and file them in the binder. He stated he was waiting for the nurse that worked the evening shift when resident came back form dialysis to report on duty at 2:00 PM to ask whether she was collecting the forms from Resident #48. He stated the risk of not having the communication form brought back from dialysis was omission of orders. Interview on 01/13/25 at 2:04 PM with the RN G revealed she was the nurse who worked with Resident #48 when she came back from dialysis. She stated it was her responsibility to collect the communication forms from Resident#48 when she came back from dialysis. She stated at times she would call dialysis and was told the form would be sent, but it was not sent. She stated she did not document her communication with dialysis nor notify the facility management of the missing communication forms. RN G stated the communication forms were important to ensure there was communication between dialysis and the facility. She stated the risk for not getting the communication form back from dialysis was the nurses could miss orders from dialysis. RN G stated she could not recall any in-service training on dialysis communication forms. Interview on 01/13/25 at 4:03 PM with the DON revealed his expectation was for the nurses to send Resident #48 with a communication form and get it when back from dialysis and put it in the dialysis binder. He stated he also expected staff to perform post-dialysis assessments when residents returned from dialysis, and document on the dialysis communication forms on dialysis days and in the electronic health records. She stated he expected staff to notify him if they were not getting communication forms back from dialysis, but it did not happen. The DON stated failure to collect the forms back from dialysis could result in them missing important orders from the dialysis center and delay in action if there were noted changes at the dialysis. He stated the facility had done annual training with staff, but no documentation of the training was provided. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's current, undated End Stage Disease, Care of a Resident policy reflected the following: .4. Agreements between this facility and the contacted end stage renal disease facility include all aspects of how the resident's care will be managed including. b. How information will be exchanged between the facilities.b. How information will be exchanged between the facilities

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observation, interview, and record review, the facility failed to monitor and verify that the feeding tube is in the right location (e.g., stomach or small intestine, depending on the tube) before administering medications to prevent complications for 1 of 1 resident (Resident #92) reviewed for feeding tubes and for 1 of 2 refrigerators and 2 of 2 medication rooms reviewed for pharmacy procedures. 1. The facility failed to ensure LVN J checked for residual (the amount of liquid remaining in the stomach after an enteral feeding) before administering medication to Resident #92. This failure could place residents at risk for adverse effects due to inappropriate management of g-tube care. 2. The facility failed to ensure expired medications, 2 bottles of aspirin 325 mg with expiration dates of April 2024 and December 2024, 3 acetaminophen suppositories 650 mg with expiration dates of November 2024 and 2 acetaminophen suppositories with expiration dates of July 2024 were removed and destroyed. This failure could place residents at risk for ineffective drug therapy. Findings included: 1. Record review of Resident #92's Admission MDS dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included stroke, gastronomy status(presence of an artificial opening into the stomach), and cognitive communication deficit. The MDS further reflected the resident required a feeding tube for nutrition. Resident #92's cognition was intact with a BIM score of 14. Record review of Resident #92's care plan revised on 12/26/24 reflected the resident required tube feeding to rule out dysphagia (difficulty swallowing). The plan reflected: Goal - Will remain free of side effects or complications related to tube feeding through the review date. Interventions included Check for tube placement and gastric contents/residual volume per facility protocol and record. Hold feed if greater than 45 ml aspirate. Record review of Resident #92's order summary report for January 2025 reflected the following: Check gastronomy tube placement prior to feeding and/or medication administration by aspiration of gastric contents every shift Observation on 01/08/25 at 08:50 AM revealed during medication administration, LVN J performed hand hygiene and donned the appropriate PPE, but failed to check the gastronomy tube placement before administering medications to Resident #92. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/08/25 at 9:16 AM with LVN J revealed he was supposed to check the gastric residual before administering the medication, and if more than 100, he should notify the doctor and hold medication. LVN J said the risk of not checking Resident #92's gastric residual could cause aspiration if Rresident #92 body was not absorbing the feeding as expected. LVN J stated he had received training on checking gastric residual before administering gastronomy feeding and medication. Interview on 01/08/25 at 1:49 PM with the DON revealed his expectation was for LVN J to check the gastric residual before administering medication to Resident #92 to ensure he was absorbing the feeding and medications he had received. The DON further stated Resident #92 ran the risk of not getting adequate medication, not getting the required therapy and, he risks aspiration. The DON stated he had done gastronomy feeding teaching with staff and discussed during the onboarding process, and he expected LVN J to do the right thing. He stated he would be talking to the nurse. No training documents were provided. Record review of the facility's Administering Medication Through an Enteral Feeding policy, revised March 2015, reflected the following: . 18. Confirm placement of feeding tube per physician order. By aspirating stomach contents, if no residual is aspirated check for bowel sounds, bloating, vomiting and pain. If no changes area noted proceed to administer medications/formula. .20. Check for gastric residual volume to assess for tolerance of enteral feeding. 2. Observation on 01/08/25 at 12:34 PM of the 300 and 400 halls Medication Room and refrigerator with LVN D revealed 3 acetaminophen suppositories 650 mg with expiration dates of 11/24, 2 acetaminophen suppositories with expiration dates of 07/24 in the refrigerator and 1 bottle of aspirin 325 mg with an expiration date of 4/24. Observation on 01/08/25 at 1:38 PM of the 200 and 100 Hall medication room with the ADON F revealed 1 bottles of aspirin 325 mg with an expiry date of December 2024. Interview on 01/08/25 at 12:58 PM with LVN D revealed it was all nurses' responsibility to check the medication room and the refrigerator for expired medications before they administer. She stated it was the ADON's responsibility to ensure there were no expired medications in the refrigerator and the medication room. She stated by failing to remove the expired medication, they could be administered and cause reactions, and the resident would not get the required therapy. She stated she had done training on checking for expired medications. Interview on 01/08/25 at 1:38 PM with ADON F revealed it was all nurses' responsibility to check and remove expired medications from the medication room. He stated he was responsible on ensuring there were no expired medications in the medication room. He stated he had checked the medication room and refrigerator a week ago, and he could not remember the date. He stated he missed the bottle of aspirin. He stated the facility had done training on medication storage, but no training record was provided upon request. Interview on 01/08/25 at 2:06 PM with the DON revealed the ADONs were responsible for checking for expired medication in the refrigerators and medication rooms every week.The DON stated he was responsible for supervision, and he wouldl be doing training with his ADONs. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Storage of Medications policy, revised April 2007, reflected the following: . 12. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview, and record review, the facility failed to ensure each resident's drug regimen was free of unnecessary medication for 1 of 5 residents (Resident #89) reviewed for adequate monitoring of unnecessary medication. The facility did not monitor Resident #89 for side-effects related to the use of the anti-anxiety medication Buspirone, hypnotic medication Zolpidem Tartrate, and the anti-psychotic medication Ingrezza. This failure could place the residents at risk for adverse consequences of medication. Findings included: Record review of Resident #89's admission record, dated 01/08/25, reflected the resident was a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #89's quarterly MDS Assessment, dated 12/09/24, reflected she had a BIMS score of 11, indicating mild cognitive impairment. Further review revealed she had active diagnoses of progressive neurological conditions (conditions characterized by gradual deterioration in functioning), non-alzheimer's dementia (a neurodegenerative disease that usually starts slowly and progressively worsens), anxiety disorder (a disorder characterized by significant and uncontrollable feelings of anxiety and fear), bipolar disorder (a mental health condition that causes extreme mood swings from depression to mania or hypomania), and obstructive sleep apnea (a common sleep-related breathing disorder). The behavior section of the MDS indicated Resident #89 had not exhibited any hallucinations, delusions, or physical or verbal behaviors towards others. The MDS also indicated she had received anti-anxiety, anti-depressant, and hypnotic medications. Record review of Resident #89's care plan, dated 12/11/24, reflected the following: Focus: [Resident #89] uses sedatives/hypnotic medication d/t_insomnia, AEB_inability to sleep At [sic] risk for side effects. Insomnia .Goal: The resident will be free of any discomfort or adverse side effects of hypnotic use through the review date .Interventions: Give sedative/hypnotic medications ordered by physician. Monitor/document side effects and effectiveness. and Focus: [Resident #89] uses anti-anxiety medications d/t_anxiety, AEB__restlessness At [sic] risk for side effects. Anxiety disorder .Goal: Will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date .Interventions: Monitor for adverse reactions for use of Anti-Anxiety [sic] and Focus: [Resident #89] uses antidepressant medication d/t_depression, AEB_social withdrawal At [sic] risk for side effects. Depression .Goal: Will show decreased episodes of s/sx of depression through the review date .Interventions: Monitor/document side effects and effectiveness. Record review of Resident #89's undated physician's orders reflected orders for the following medications: - Ingrezza Oral Capsule 80 MG (Valbenazine Tosylate) Give 1 capsule by mouth one time a day for bipolar disorder with a start date of 12/12/24; (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Zolpidem Tartrate Oral Tablet 10 MG (Zolpidem Tartrate) Give 1 tablet by mouth at bedtime for insomnia with a start date of 11/21/24; and - Busprione HCl Oral Tablet 10 MG (Buspirone HCl) Give 1 tablet by mouth two times a day for anxiety with a start date of 11/21/24. The orders did not include any orders to monitor for side-effects related to the use of the Ingrezza, Zolpidem, or Buspirone. Record review of Resident #89's January 2025 MAR/TAR revealed she had been receiving the Ingrezza, Zolpidem, and Buspirone as ordered each day. The MAR/TAR did not include documented evidence the facility was monitoring for side-effects related to the use of the Ingrezza, Zolpidem, or Buspirone. Record review of Resident #89's December 2024 and January 2025 progress notes did not reflect any information related to her use of Ingrezza, Zolpidem, or Buspirone. Observation and interview on 01/13/25 at 11:00 AM with Resident #89 revealed she was resting in bed and said she was doing great. She said she was not experiencing any side effects to any medications she was taking. Interview on 01/13/25 at 11:42 AM with LVN T revealed he was Resident #89's nurse and the resident had been receiving all her medications as ordered. LVN T said Resident #89 was not showing any side effects to any medications she had received. LVN T said he thought Resident #89 had orders for side effect monitoring but he looked in her chart and said there were not any orders like that. LVN T said he saw monitoring orders for other medications but not the Ingrezza, Zolpidem, or Buspirone. LVN T said the side effect monitoring orders should have been added when the orders were put in the system and he was not sure why they were not included already. Interview on 01/13/25 at 3:47 PM with the DON revealed certain medications should be monitored for side effects. The DON said the nurse who added the orders to Resident #89's chart should have also added the additional side effect monitoring orders as well. The DON said the purpose of that was to ensure the resident would not experience untoward outcomes and if they did the facility could remediate that quickly. The DON said if staff were not monitoring the side effects of medications, the resident could experience a change in condition related to the medications. The DON said the orders to monitor for side effects remind staff what to look for on each shift to catch a change in condition quickly. The DON said usually the consulting pharmacist, the ADON's, or the nurses would be responsible for ensuring the side effect monitoring for medications was included in a resident's chart. Record review of the facility's Adverse Consequences and Medication Errors policy, revised April 2014, reflected: 1. Residents receiving any medication that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported. 2. An adverse consequence is defined as an unpleasant symptom or event that is due to or associated with a medication, such as an impairment or decline in an individual's mental or physical condition or functional or psychosocial status. An adverse consequence may include: a. Adverse drug/medication reaction; b. Side effect; c. Medication-medication interaction; or d. Medication-food interaction.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44937 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 2 of 10 residents (Residents #7 and #9) reviewed for infection control. 1. The facility failed to ensure CNA M used Personal Protection Equipment during urinary catheter care performed for Resident #7 while on EBP precautions. 2. The facility failed to ensure RN C used Personal Protection Equipment during medication pass and providing care for Resident #9's tube feeding cite while on EBP precautions. These failures could place residents at risk for cross contamination and the spread of infection. Findings included: Record review of Resident #7's face sheet dated 01/08/25 reflected Resident #7 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #7's quarterly MDS assessment dated [DATE] reflected Resident #7 had a BIMS score of 99, indicating Resident #7 was not able to complete the interview. The MDS indicated Resident #7 was dependent on staff with toileting, showering/bathing and personal hygiene. The MDS further reflected Resident#7 had use of a feeding tube. Resident #9's diagnoses included heart failure, hypertension (high blood pressure), gastro-esophageal reflux disease without esophagitis (acidic stomach contents flows back up to the esophagus), gastronomy status (presence of an artificial opening in the stomach). Record review of Resident #7's care plan reflected Resident #7 required a feeding tube related to dysphagia, weight loss. The care plan reflected: Goal: Resident will maintain adequate nutrition, hydration, weight and show no signs or symptoms of malnutrition or dehydration. Interventions included: Check for placement and gastric contents, keep head of bed elevated 30-45 degrees, provide local care to g-tube site and monitor for signs and symptoms of infection. The care plan further reflected Resident #7 required enhanced barrier precautions due to being at risk of infections related to having an indwelling medical device, specifically a feeding tube. The care plan reflected: Goal: will reduce risk of infection. Interventions included: obtain and monitor labs and diagnosis as ordered. Report to physician any signs or symptoms of infection, sanitize hands before entering and leaving the resident's room, wear gloves and gown during high-contact care activities for resident with indwelling medical devices, wounds and colonize or infection. Record review of Resident #7's orders reflected the following orders: ENHANCED BARRIER PRECAUTIONS every shift for related to G tube Active 1/4/2025 G-Tube: Check G-Tube placement prior to feeding and/or medication administration by aspiration of gastric contents every shift 1/4/2025 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G-Tube: Document total intake q shift to include formula and free water flushes every shift Active 1/4/2025 G-Tube: Monitor GT site for signs/symptoms of infection every shift Active 1/4/2025 G-Tube: Cleanse PEG site with Normal Saline, pat dry and apply dressing daily and as needed every day shift Active 1/4/2025. Observation on 01/08/25 at 3:25 PM revealed RN C performed hand hygiene and donned gloves; however, she did not wear a gown when completing medication pass and care for Resident #7's tube feeding site. Interview on 01/13/25 2:05 PM with RN C revealed she was aware of an orange dot at the door of Resident #7 which indicated she was on enhanced barrier precautions. RN C pointed out the dot at the door along with personal protective equipment located inside Resident #7's room. RN C stated when providing care or service to residents, both nurses and aides were responsible for ensuring they wore a gown and gloves. RN C stated, I did not wear a gown during care and not doing so placed [Resident #7] at risk of infection. According to RN C, she could not say why she did not wear a gown, but stated she knew it was facility policy to do so. RN C stated she had been trained to do so and was alerted by the orders in the system. Record review of Resident #9's face sheet dated 01/13/25 reflected Resident #9 was a [AGE] year-old female admitted to the facility on [DATE]. Record review of Resident #9's quarterly MDS dated [DATE] reflected Resident #9 was cognitively intact with a BIMS score of 13. The MDS indicated Resident #9 required substantial/maximum assistance with toileting, showering/bathing and personal hygiene. The MDS further reflected Resident#9 had an indwelling catheter. Resident #9's diagnoses included debility (weakness), cardiorespiratory conditions (conditions that affect the structure or functions of the heart), Neurogenic bladder (lack of bladder control due to spinal chord, brain injury, or nerve problems), irritable bowel syndrome (condition that affects the stomach and intestines) with diarrhea and cervical disc disorder with myelopathy (condition that is caused by age related changes to the bones, ligaments and discs of the neck). Record review of Resident #9's care plan reflected Resident #9 had an indwelling Foley catheter related to two or more post voiding residual urine volumes greater than 200 cc. The care plan reflected the goal was for the resident not to show signs or symptoms of urinary tract infection. The care plan interventions included changing the catheter as ordered, checking for patency and urinary output every shift, checking tubing for prints, observing for pain and discomfort due to the catheter, reporting to the physician any signs of urinary tract infection, positioning the catheter at the lowest position. The care plan reflected Resident #9 required enhanced barrier precautions due to being at risk of infections related to having a Foley catheter. The care plan goal was Will reduce risk of infection. The care plan interventions included: obtain and monitor labs and diagnosis as ordered. Report to physician any signs or symptoms of infection, sanitize hands before entering and leaving the resident's room, wear gloves and gown during high-contact care activities for resident with indwelling medical devices, wounds and colonize or infection. Record review of Resident #9's physician order reflected the following orders: (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	FC: Foley catheter care Every shift and PRN; every shift Active 12/5/2024 Enhanced Barrier Precautions; every shift for related to foley Active 11/20/2024 Observation on 01/08/25 at 9:51 AM revealed CNA M completing incontinence care for Resident #9. CNA M used proper hand hygiene by washing her hands and using gloves; however, CNA M never donned a gown or face shield. Interview on 01/08/25 at 10:08 AM with CNA M revealed she was aware Resident #9 was on enhanced barrier precautions because of her use of a catheter. CNA M stated she was responsible for ensuring she donned the required personal protection equipment prior to providing care. CNA M stated there was an orange dot at the door which alerted staff to use proper personal protection equipment when competing care. CNA M stated personal protection equipment included gloves and a gown. She stated while she did wear gloves, she forgot to get a gown which was located inside the resident's room near the door frame. CNA M stated she was nervous and just was not thinking straight. According to CNA M, not wearing a gown when completing care for Resident #9 placed her risk of infection and contamination. Interview on 01/13/25 at 1:48 PM with LVN D revealed she worked with Resident #9 on 6:00 AM-2:00 PM shift and was aware she was on enhanced barrier protection. LVN D stated aides were expected to use gloves and gowns due to Resident #9's use of a catheter. According to LVN D, CNAs were responsible for donning personal protection equipment when completing catheter care to prevent risk of infection. LVN D stated CNA M informed her that she forgot to don all the required equipment and LVN D stated she was responsible to ensure aides were knowledgeable of which residents were on enhanced barrier protection alerted by an orange sticker at the door. Interview on 01/13/25 3:46 PM with the DON revealed CNAs were responsible for donning personal protective equipment when completing care for residents, who were on enhanced barrier precautions. The DON stated residents who required the use of a tube feeding machine or catheter required all staff to don PPE prior to the start of care. The DON stated he expected CNAs to follow the facility's policy when it came to enhanced barrier precautions. He stated not doing so placed residents at risk of transmission of any type of infection from patient to patient. Record review of the facility's Enhanced Barrier Precautions- Policy, dated 04/01/24, reflected: The policy outlines the guidelines and procedures to implement enhanced barrier precautions to prevent the spread of infectious diseases among residents and staff. Enhanced Barrier Precautions are used in conjunction with standard precautions and expand the use of personal protection equipment to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multi drug resistant organisms to staff hands and clothing. For resident for whom Enhanced Barrier Precautions are indicated, it is employed when performing the following high - contact resident care activities. Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing. Indwelling medical device examples include central lines, urinary catheters, feeding tubes and tracheotomies.