

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676453	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Simpson Place		STREET ADDRESS, CITY, STATE, ZIP CODE 3922 Simpson Street Dallas, TX 75246	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786</p> <p>Based on interviews and record review, the facility failed to implement a comprehensive person-centered care plan for each resident, consistent with the rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 4 residents (Residents #1) reviewed for care plans.</p> <p>The facility failed to complete a weekly skin assessment on Resident #1 from 04/14/24 through 04/20/24.</p> <p>This failure could place residents at risk of receiving inadequate care.</p> <p>Finding Included:</p> <p>Record review of Resident #1's Face Sheet dated 05/14/24, reflected a [AGE] year-old female with an initial admitted [DATE] and a re-admitted [DATE]. The Face Sheet reflected Resident #1 had a diagnosis of Urinary Tract Infection (inflammation of the urinary tract), Dementia (impaired ability to think, remember, or make decisions), absence of left leg above knee, and Hemiplegia and Hemiparesis following cerebral infarction affecting left nondominant side (paralysis on one side of the body and weakness or inability to move on one side of the body due to past stroke).</p> <p>Record review of Resident #1's care plan dated 05/14/24, with an initial date of 03/29/24, with a revision date of 04/05/24, reflected the following:</p> <p>Inspect skin complete body head to toe every week and document results</p> <p>Record review of the Wound Report dated 05/14/24 reflected Resident #1 had a stage 3 pressure wound of the left ischium</p> <p>Record review of the facility's skin data sheets revealed the resident did not have a head-to-toe inspection from 04/14/24 through 04/20/24. It noted Resident #1 received a head-to-toe skin assessment on 04/13/24 and the next assessment did not occur until 04/21/24.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/15/24 at 12:17 PM, ADON A stated she and DON B were responsible for ensuring the completion of weekly skin assessments. ADON A stated she guessed she and DON B missed the audit the week Resident #1 did not receive the head-to-toe skin assessment. ADON A stated the risk of not completing the head-to-toe skin assessment was not knowing if a wound had gotten larger.</p> <p>In an interview on 05/15/24 at 2:26 PM, DON B stated ADON A was responsible for completing the skin assessment audit. DON B stated the audits were completed weekly if not daily. DON B stated the risks of not completing the weekly head-to-toe skin assessments were skin breakdown, sores, and pressure sores.</p> <p>In an interview on 05/15/24 at 3:52 PM, Administrator C stated the risk of not completing the weekly skin could have a variety of outcomes, a variety of negative outcomes. Administrator C did not elaborate.</p> <p>Record review of the facility's policy dated 04/2012, with a revision date of 07/2018, titled, Care Plan Relating to Skin and Wound Care reflected the following:</p> <p>Purpose</p> <p>A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable.</p> <p>A resident with pressure ulcer(s)/pressure injury(s) receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>Record review of the facility's policy dated 04/2012, with a revision date of 07/2018, titled, Skin Data Collection: Licensed Nurses, reflect the following:</p> <p>Procedure</p> <p>Weekly, the licensed nurse performs a head-to-toe check of the patient's/resident's skin, paying attention to:</p> <p>A. The surfaces of the skin that come in contact with the bed and chair.</p> <p>B. Boney prominences</p> <p>C. The surfaces of the skin that come into contact with any orthotic device, tube, brace, or positioning device, breast and gluteal folds</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786</p> <p>Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #1) of 3 residents reviewed for infection control.</p> <ol style="list-style-type: none"> 1. RN D failed to not remove his gloves over Resident #1's open wound. 2. RN D failed to not perform hand hygiene with hand sanitizer over Resident #1's open wound. <p>These failures could put residents at risk of worsened or infected wounds.</p> <p>Findings included:</p> <p>Record review of Resident #1's Face Sheet dated 05/14/24, reflected a [AGE] year-old female with an initial admitted [DATE] and a re-admitted [DATE]. The Face Sheet reflected Resident #1 had a diagnosis of Urinary Tract Infection (inflammation of the urinary tract), Dementia (impaired ability to think, remember, or make decisions), absence of left leg above knee, and Hemiplegia and Hemiparesis following cerebral infarction affecting left nondominant side (paralysis on one side of the body and weakness or inability to move on one side of the body due to past stroke).</p> <p>In an observation on 05/14/24 at 12:34 PM, RN D was observed as he removed the dressing from Resident #1's wound on her left ischium. After he removed his gloves, RN D was observed as he performed hand hygiene using hand sanitizer over Resident #1's open wound. RN D then donned a new pair of gloves to redress the wound. RN D was observed as he doffed the pair of gloves over Resident #1's open wound.</p> <p>In an interview on 05/14/24 at 3:20 PM, RN D stated he was a little nervous during the observation and did not realize he had used sanitizer over the wound and did not realize he took his gloves off over the wound. He stated the risk of doing hand hygiene or changing gloves over the wound was the risk of micro-organisms falling into the wound. He stated he usually would have completed those tasks on the side of the resident and not over the wound.</p> <p>In an interview on 05/15/24 at 12:17 PM, ADON A stated the risks of RN D doing hand hygiene and removing gloves over the wound was infection, because something could have fallen in the wound. She stated RN D was new at the facility, but he was a registered nurse and knew the basics of wound care.</p> <p>In an interview on 05/15/24 at 2:26 PM, DON B stated, Oh my gosh, he did it over the wound?. DON B stated RN D was trained to not complete hand hygiene or remove gloves over wounds. DON B stated RN D did tell her he was nervous during the process. DON B stated the risk of doing hand hygiene or taking off gloves over the wound was bacteria or sanitizer could have gotten into the wound.</p> <p>In an interview on 05/15/24 at 3:52 PM, Administrator C stated cross contamination could have occurred when RN D used hand sanitizer and took off his gloves over Resident #1's wound.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's policy dated 07/2018, with revision dates of 01/2021 and 02/2022, titled, Infection Prevention and Control Surveillance, reflected the following:</p> <p>Purpose:</p> <p>The surveillance of infections is an essential part of any infection prevention and control strategy. The main objectives of a surveillance program are:</p> <p>I. the prevention and early detection of outbreaks to allow timely investigation and control</p> <p>II. the assessment of infection rates over time to determine the need for, and measure the effect of, preventative or control measures</p>		