STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676453	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Simpson Place	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observations, interviews, and record review, the facility failed to ensure residents had the right to be free from abuse and not use verbal and mental abuse for 1 (Resident #1) of 8 residents reviewed for abuse. The facility failed to ensure CNA A did not snatch the call light out of Resident #1's hand and verbally abuse Resident #1, during patient care in her room on 05/19/24. This failure could place residents at risk of injury causing fractures, bruising, skin tears, and psychological harm resulting in in decreased health and psycho-social well-being. Findings included: Record review of Resident #1's MDS assessment dated [DATE] revealed a [AGE] year-old female who admitted [DATE] with a BIMS Assessment score of 06 (Moderate Cognitive impairment). She did reject care 1 to 3 days with no upper and lower extremity impairments. She used a wheelchair and needed substantial/maximal assistance with toileting, dressing, and personal hygiene. She had medically complex conditions, hypertension, Viral hepatitis, CVA, non-Alzheimer's dementia, seizure disorder, malnutrition, anxiety, depression, respiratory failure, dysphagia, and acute respiratory failure. Record review Resident #1's Care Plan dated 05/07/24 by RN L revealed, Cognitive deficit, impaired physical mobility, self-care deficit, chronic constipation, on 05/20/24 Behavioral changes: receive culturally competent trauma-informed care and accounting for resident's experiences and preferences in order to reduce triggers that may re-traumatize - Maintain respectful physical and emotional boundaries . Record Review of Resident #1's Nurses Note dated 05/19/24 at 6:46 pm by MDS Coordinator D revealed, Resident on the light all day. She screamed at the aide while the aide was changing her. Staff met all of residents needs during time light was answered. Resident screaming out of room and into the hallway off and on all day. Denies having any pain and distress noted. Resident may need psych consult. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Nurses Note dated 05/19/24 at 9:18 pm by MDS Coordinator D revealed, While rounding on this resident a FM called and said to this nurse, 'She may have heard that Resident #1 had been on her light constantly all-day'. I replied and told the FM the staff did tell me she had been very anxious and very active on her call light today'. She starts telling me that 'She sent the DON an email today regarding Resident #1 and the CNA interaction today'. She continues by stating 'That the aide was verbally abusive to Resident #1 today and she made Resident #1 get out of bed against her will'. She also started using the word neglect towards Resident #1. 'She stated that she has it all on video'. I informed her that we take these allegations very seriously and I will be sure the proper people were informed. The abuse coordinator, administrator, has been informed and the DON. Record review of Resident #1's Nurses Notes from 12/13/23 - 05/17/24 revealed Resident #1 had no recurrent outburst of screaming or yelling at the staff or pressing her call light constantly for long periods of time until 05/19/24. Record review of Resident #1's Incident/accident Report dated 05/19/24 by MDS Coordinator D revealed, Type of incident: Abuse/neglect allegation, reported 05/19/24 at 8:00 pm. There was no witnesses, incident date/time: 05/19/24 at 7:30 am, no apparent injury, in resident's room- bed, resident was lying in bed. Resident #1's cognitive status: moderately impaired, cognition varies throughout the day, impaired sitting balance, and impaired standing balance. Resident #1 was total dependent, full weight bearing, incontinent, wheelchair used, vision and hearing adequate .abuse coordinator called and referrals to social services . Record review of Resident #1's Provider Investigative Report dated 05/24/24 by Administrator B revealed, the facility reported Resident #1's abuse allegation on 05/20/24 at 12:57 pm and determined the allegation occurred on 05/19/24 at 7:30 am. Resident #1 had no prior history of abuse, and the AP denied the abuse allegation. Witness: video camera in Resident #1's room, the FM said she witnessed a CNA verbally abuse Resident #1 and made her get up against her will via the camera in the room. Resident #1 was assessed by MDS Coordinator D revealed no injury or adverse effects and no treatment was provided, and the incident was reported to the police. Provider Response: Employee was sent home pending investigation. Clinical Assessment completed for Resident #1. MD/RP, Administrator C Notified, the DON Notified. Notified Local Authority, Incident # XX-XXXXXXX. Conducted Resident Safe Surveys. Scheduled visit from XXX for Psychological services for psychosocial support. Investigation Summary: On 5/19/24, @ approximately 7:50pm FM N called the facility and notified the charge nurse, MDS Coordinator D that she saw on camera in the room, an aide was verbally abusive to Resident #1, and she made Resident #1 get up against her will. She said the incident happen at 7:30 am that morning. MDS Coordinator D notified the Administrator C and DON. FM N sent copy the videos via email on Wednesday, May 23 [SIC], 2024, to the administrator . In video #1, CNA A removes the call light from Resident #1's hand and tosses it to the ground . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In Video #2, CNA A refuses to change Resident #1 when she tells CNA A, she is wet . In Video #3, No previous audio is heard, then you hear CNA A say, I ain't scared. I'll fight back then Resident #1 says I wasn't calling no one CNA A continues to tell Resident #1, I don't know what your problem is today. You talking crazy to me . In video #4, CNA A walks in and says, What is it? You fixing to get up. Resident #1 says she needs to poop. CNA A says you fixing get up. I'm not playing games . No witnesses other than the camera. CNA A was suspended pending investigation. A review of CNA's employee file reveals CNA A was hired on 9/21/22. Prior disciplinary actions include tardies. No prior allegations. CNA A denies the allegations and says she was talking to her boyfriend via ear buds while providing care. CNA A was terminated, and her license was referred to the state. Resident #1 is a [AGE] year-old female with a diagnosis of unspecified Dementia and a BIM score of 6. She remains in the facility and denies a distress from the event. It is possible CNA A was talking to someone on her ear buds because Resident #1 is not heard speaking at all before CNA A says I ain't scared. I'll fight back . Notified Dallas police event# xx-xxxxxxx. Safe surveys conducted and concluded that participants felt safe. Scheduled visit .for psychological services for psychosocial support. Staff in-service on abuse and neglect. Based on staff interviews, record review, and resident observation monitoring, it is determined that there is no negligence noted by [This Facility] Were other parties notified: Notified Police, Incident# xx-xxxxxxx. Investigation Findings: Inconclusive Provider Action Taken Post-investigation: Resident #1 remains stable in the facility with no negative outcomes. Care plans reviewed and updated as needed. In-service initiated for staff on abuse and neglect. CNAs license was referred. CNA was terminated. Any trends will be evaluated in QAPI meeting as needed. Record review of the Abuse In-service Trainings conducted by the DON on 05/19/24 revealed 14 employees received the Abuse training. Record review of the Abuse In-service Trainings conducted by the SW on 05/23/24 revealed 12 employees received the Abuse training. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CNA A's Notice of Warning form dated 05/20/24 revealed, Investigatory Suspension, suspend pending abuse allegation. Record review of CNA A's Community Personnel Action effective date 05/23/24 by Administrator B revealed, Not eligible for rehire, termination: Discharge - violated company policy: Employee terminated due to allegation of abuse. Record review of CNA A's Timecard revealed she worked on 05/19/24 from 6:15 am to 6:48 pm and had not worked at this facility since then. Interviews between 05/21/24 at 10:30 am to 05/22/24 at 5:58 pm and revealed CNA J, LVN M, LVN N, Medication Aide O, [NAME] I, Dietary Aide, Central Supply P, ADON Q, and MDS Coordinator D had been trained on abuse and to report it immediately to the Abuse Coordinator, the Administrator. In an interview on 05/21/24 at 4:40 pm, Resident #1 stated a few days ago one of the CNA's was abusive to her, she was yelling at her, and mean by the way she talked to her. She stated this CNA was a bad person because she constantly did things to aggravate her. She stated this CNA said things to her she should not have said and that was why she had to report it. She stated she could not remember the CNA's name and description and had not seen her at the facility since this occurred. She stated she felt safe and was glad that CNA was not coming back to ever care for her again. In an interview on 05/22/24 at 04:52 pm, the SW stated Resident #1 complained about CNA A being rude to her on Sunday (05/19/24). And after review of Resident #1's video they were able to determine it was CNA A who was then suspended at that time. In the video CNA A told Resident #1 she needed to get out of bed, and it was CNA's tone that was not right. She stated it was hard to hear much of what was said. In an interview by phone on 05/22/24 at 5:13 pm, CNA A stated why was the HHSC Investigator wanting to talk to her then said she already knew why the HHSC Investigator called her. She stated this call had do with her being suspended. She stated she was suspended because of an allegation made by Resident #1 and the Administrator felt like she was rude to this resident. She stated on 05/19/24, she was on the phone talking to someone else while she was caring for Resident #1 and was not yelling at her. She stated she was not abusive to Resident #1 or anyone else and added she had been suspended since Sunday night 05/19/24. She stated she received a call from the staffing coordinator she was suspended and stated she spoke to Administrator B and gave her statement to her. She stated she was not going to go back to this facility, and she was fine if she gets fired. In an interview on 05/22/24 at 5:19 pm, Administrator B stated they suspended CNA A last Monday 05/20/24 and reported it to HHSC. She stated after she further reviewed the video, CNA A would be terminated, and they were currently doing safe surveys, and social worker notes. She stated CNA A wrote a statement denying the allegation of abuse. She stated CNA A was not physically abusive but was verbally/mentally abusive to Resident #1. She stated Resident #1's mood was fine and told the SW she was glad CNA A no longer worked at this facility. Observation on 05/22/24 at 5:25 pm of Resident #1's Video footage dated 05/19/24 at 7:41 am - 7:44 am revealed: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA A yelled: What is it? (turning off call light), you finna get up, you, you you finna get up, that's it, naw you finna get up, uh uh. Resident #1: Uh uh I have to poop (bowel movement). CNA A yelled: And you're still finna to get up, you're finna get up, I'm going to teach you about riding the lights. Resident #1: I got to boo boo (have a bowel movement). CNA A yelled: And you still finna to get up, it don't matter you getting up early, you want to ride the light, let's get up, you want to press the light all night long, let's get up yeah early, you gone stop oneday and you still have to get up, oh yeah you finna get up uh huh. Resident #1: Oh okay CNA A yelled: Yeah I'm not playing games with nobody this morning and (started putting on her gloves, pulled Resident #1's bed covers down to her feet and laid the resident down flat and turned the small fan off) and at 7:42 am snatched the call light out of Resident #1's hand and threw it to the other side of her bed, CNA A went to the closet to get clothes and said Yes Jesus won't he do it then she went through a bag to get clothes, then the video ends. Observation on 05/22/24 at 5:26 pm of Resident 1's video footage dated 05/19/24 at 10:11 am - 10:13 am revealed, CNA A said: You don't have to worry about me no more baby, nobody does. Resident #1: You going to take off my clothes, my pants. CNA A yelled: No, I'm not, I'm leaving them on. Resident: #1 They're kind of wet. CNA A yelled: No, your clothes are not wet. Resident #1: These are wet, they soaking . (cut off by CNA A) CNA A yelled: First of all, you don't have on any pants so what are you talking about. Resident #1: Okay these are soaking wet (Resident #1 has white phone in her hand pressing the buttons). CNA A yelled: I don't care who you call, I'm not scared, at all I'm not scared, I fight back. Resident #1: I wasn't calling somebody; I wasn't calling nobody. CNA A yelled: I fight back. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1: So. CNA A yelled: So. Resident #1: I do too. CNA A yelled: Resident #1 [calling resident by her first name] I don't know what your problem is today, but you . Resident #1: No, you're talking to me crazy. CNA A yelled: No, you're talking to me crazy. Resident #1: You're talking to me crazy. CNA A yelled: Bye Resident #1 [calling resident by her first name] bye and (walked out of the resident's room Resident #1: Bye . then the video ends. In an interview on 05/22/24 at 5:46 pm, the DON stated Resident #1 was good at telling her things, but she had not reported anyone being abusive to her. She stated she got a call Sunday night 05/19/24 from MDS Coordinator D saying one of the staff members had been rough or rude to Resident #1. She stated the Former Administrator was notified and CNA A was suspended, and the police were called. She stated Resident #1 had no change in mood and after reviewing the videos she did not see physical abuse. She stated she saw CNA A was verbally abusive to Resident #1 and when she first looked at Resident #1's videos, she was like wow, and had never seen CNA A acting like that before. She stated CNA A had no complaints about being rude or abusive to the residents prior to this incident. She stated she was surprised at how her tone was with Resident #1. She was not good with communicating with the resident. She stated the facility was still investigating this allegation. In an interview on 05/22/23 at 10:52 am, Former Administrator C stated he came up to this facility to review Resident #1's videos. He stated after seeing what transpired in the videos, he told the new Administrator B what he saw in the videos was terminable. He stated he spoke to FM N because Resident #1 was not interviewable. He added the takeaway from the videos were very concerning and he was pretty surprised at what he saw. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/22/24 at 3:25 pm, FM N stated she had seen that CNA prior to this and noticed she had an attitude and frown on her face. She stated she had to say hello to that CNA first and she would respond Fine and was very short in conversation and was snappy with other residents and Resident #1 in the past. She stated she emailed the DON and SW that a CNA was rude when talking to Resident #1. She stated around on 05/19/24 at 10:50 am, Resident #1 called her upset crying very badly, her voice was shaky, and she was hysterically upset. She stated Resident #1 said a CNA came into her room and threatened her and was mean and disrespecting to her. She stated Resident #1 said this CNA yelled at her and was mean and rude to her and talked down to her. She stated after she spoke to Resident #1 on 05/19/24, she reviewed the video camera in Resident #1's room. She stated she could see on this day (05/19/24) at 7:27 am, a CNA was verbally abusive to Resident #1. She stated she called the facility six or seven times, but no one answered the phone. She stated she emailed the DON and the SW about how that CNA treated Resident #1 on 05/19/24. She stated she was eventually able to talk to LVN K about not letting that CNA work with Resident #1 any longer this day (05/19/24), to not go back into Resident #1's room because that CNA had been rude to Resident #1. He said okay, he would ensure that CNA would not go back in there. She stated she emailed the DON and the SW on 05/19/24 at 2:31 pm that the CNA caring for Resident #1 that day (05/19/24) was verbally abusive and neglectful. She stated she had no response from anyone until the SW called her 05/20/24 saying she referred Resident #1's grievance to the Abuse Coordinator, Administrator C. She stated she had since spoke to the DON about this matter, and she said the DON was flabbergasted about what had happened between Resident #1 and that CNA. She stated what that CNA did to Resident #1 made her feel uneasy and was disheartening especially when the CNA took an oath to take care of people. She stated she felt better now knowing that CNA was no longer there to care for Resident #1 or anyone else. Record review of the facility's Abuse and Neglect .policy and procedure dated June 23, 2017 and revised February 12, 2020 revealed, The purpose: of this policy is to ensure that all healthcare facilities comply with federal and state regulations regarding (i) protecting facility patients and residents from abuse, neglect, exploitation, and misappropriation of resident property, and (ii) timely investigation of and reporting to state and local agencies all allegations of abuse, neglect, exploitation, and misappropriation of resident property. All managed healthcare facilities and all management company staff members or third parties providing services to such facilities and/or their residents. Policy: 1. Resident Rights. Each resident has the right to be free from abuse, neglect, exploitation, misappropriation of resident's property, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse, neglect, exploitation, misappropriation of resident's property by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, resident representative, friends, or other individuals. 2 Facility Duty to Protect Resident Rights. The facility must prohibit and prevent abuse, neglect, and exploitation of residents, and misappropriation of resident property. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observations, interviews, and record review, the facility failed to ensure all assistive devices were maintained and free of hazards for two (Residents #2 and #3) of 8 residents reviewed for medical equipment. The facility failed to properly maintain Residents #2 and #3's wheelchair armrests. These failures could place residents at risk of skin tears, bruises, and falls which could lead to bleeding, and pain resulting in a decline in their health and psycho-social well-being. Findings included: 1) Record review of Resident #2's Admission MDS assessment dated [DATE] revealed a [AGE] year-old male who admitted [DATE] with a BIMS Score of 05. He used a wheelchair with an active diagnoses of having a stroke and has had one fall with no injury since he admitted . Review of Resident #'2s plan of care dated 05/14/24 for fall risk related to fall, history of hemiplegia, history of hypertension, fall risk score 7-8 high risk and evidence by joint mobility (joint range and motion) interferes with balance, paralysis, left upper extremity weakness, left lower extremity weakness, and cognitive status. And for impaired physical mobility dated 04/16/24 related to history of hemiplegia and cardiovascular disease . Observation on 05/21/24 at 11:55 am, Resident #2 was not interviewable and was sitting in the TV/common area room next to the nurse's station. Resident #2 was sitting in a recliner wheelchair. The right armrest only had 2x1 inches diameter of vinyl was missing and there were small, jagged edges of vinyl, and the exposed cushion appeared brownish. And the left side armrest of his wheelchair was missing, and the metal part of the wheelchair was exposed. In an interview on 05/21/24 at 11:58 am Medication Aide F stated she had not noticed Resident #1's wheelchair armrests were not in good repair. She stated broken armrests could cause Resident #2 to fall or get pressure sores, itchiness, and redness of his skin. In an interview on 05/21/24 at 12:04 pm MDS Coordinator D stated she had not noticed his wheelchair armrests were not in good repair. She stated she was in the office a lot and added she was not aware if he had any falls or not. She stated residents in torn or missing armrest could cause skin tears, pressure wounds, or scrape their arms. She stated they used teamwork between central supply, maintenance, and nursing to report to maintenance any issues with the residents' wheelchairs. She stated she was going to get the Maintenance Director right now to fix them. In an interview on 05/21/24 at 12:09 pm, CNA F stated she was not sure if that was Resident #2's personal wheelchair, she believed he was just borrowing it. She stated she was not sure why the wheelchair's armrests were torn and missing. She stated she would see if she could find him another wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/21/24 at 12:10 pm, the ADON stated she was working the floor and was Resident #2's charge nurse for this day. She had not noticed his wheelchair had torn and missing armrests. She stated she was not sure what type of wheelchair he was in. In an interview on 05/21/24 at 12:15 pm, the Central Supply Director stated she had not noticed Resident #2's wheelchair having torn and broken arm rests and was not sure who put him in that wheelchair. She stated all staff were responsible for reporting broken wheelchairs to the maintenance department. She stated if the resident's wheelchair arm rests were torn, or broken residents could get skin tears or could cause them to fall. She said she would get with the nursing department to get him another wheelchair. Observation on 05/21/24 at 12:22 pm, Resident #2 was being pushed by staff to the dining room and was in another wheelchair that appeared new with no torn or missing armrests. 2) Record review of Resident #3's Annual MDS assessment dated [DATE] revealed a [AGE] year-old female who admitted [DATE] with a BIMS score of 07 and used a walker. She was diagnosed with medically complex conditions and had no falls since she admitted . Review of Resident #3's Care Plan dated 04/06/24 revealed, Cognitive deficit, as evidenced by short term memory loss, fall risk related to: fall risk score of 7-8 high risk, as evidenced by cognitive status, impaired physical mobility as evidenced by: assist rails. Observation and interview on 05/21/24 at 12:27 pm, Resident #3 was sitting in the dining room at the table waiting to get her food. And her right wheelchair armrest had approximately seven inches of missing vinyl that was torn off, most of the cotton was missing, and there was a thin layer of brownish cotton left. She stated in the past she put tape around her wheelchair armrests. She stated she spoke to the Maintenance Director about fixing her wheelchair and was being patient on getting it fixed. She stated she was doing the best she could to get around. Interview and observation on 05/22/24 at 10:35 am, Resident #3 was sitting in her wheelchair, the vinyl of the left arm rest was torn and jagged in the middle part of it. And the right arm rest was still missing most of the vinyl and the cotton was exposed. She stated she put tape on them before, but they took the tape off of them. She stated she wanted to tape her armrests again, to keep them from tearing any further, and added it had been over a year that her wheelchair's armrests were like this. She stated when she asked the staff about getting them fixed, they said they would let the Maintenance Director know. She asked the state surveyor would she please try to get her wheelchair arm rests fixed. Interview on 05/22/24 at 10:41 am, the ADON stated she never noticed Resident #3's wheelchair arm rests being torn and said she would report it to the maintenance man. She stated having bad armrests could cause the residents to have skin problems. Interview and observation on 05/22/24 at 12:56 am, Resident #3 was leaving the dining room and was using her left arm and leg to move her wheelchair. She had a drink in her right hand and both of her armrests were fixed and appeared new. She stated she was so happy now. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/22/24 at 3:59 pm the Maintenance Director stated he had not noticed the resident's wheelchair armrests were torn and missing. He stated he had a maintenance assistant who also helped him, and all the staff had to do was put the repair request in the maintenance book. He stated he was responsible for repairing and replacing wheelchairs if he knew about it. He stated the staff liked to verbally tell him something needing repair but when he was busy working on something else, he has told them to write in in the maintenance book. He stated if resident's wheelchairs were not in good repair, they could have a fall and get hurt. In an interview on 05/22/24 at 5:46 pm, the DON stated she was not sure who was responsible for ensuring the wheelchairs were in good working order. She stated all staff should look at their wheelchairs when providing care, at any other times, and write it in the maintenance book if there's problems with them. She stated residents could get skin abrasions and skin infections if there armrests were not properly covered. She stated germs could get in their skin for a skin tear or cut. In an interview on 05/22/24 at 7:43 pm, Administrator B was not aware of any issues with the resident's wheelchairs not being in good working order and would get with maintenance to address. In an interview on 05/22/24 at 10:52, Former Administrator C stated this facility had no issues or complaints about wheelchair armrests being in disrepair. He stated the staff looked at the wheelchairs and switched or replace them when issues were identified. Record Review of the Maintenance log dated from 05/08/24 to 05/22/24, reflected no entries to repair wheelchair armrests. Record review of the Maintenance Repair policy was requested 05/21/24 and 05/22/24, but not provided. A review of the facility's policy Incident/Accident prevention policy was requested 05/21/24 and 05/22/24, but not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676453	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Simpson Place	3922 Simpson Street Dallas, TX 75246

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32581 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 (Dietary Aide G) of four dietary staff reviewed for food services. Dietary Aide G failed to properly wear a hair restraint effectively covering all of her hair, while preparing the food for the residents, from the steam table on the 600-hall floor. This failure could place residents at risk for food contamination and foodborne illness which could result in gastro-intestinal issues and loss of desire to eat the food and emotional distress. Findings included: Observation and interview on 05/22/24 at 12:52 pm, Dietary Aide G was on the 600-hall floor standing in front of the mobile food hot cart (Steam table). She was preparing the resident's meal plates and her hair was approximately 3 inches in length. She had a brown 2-inch diameter hair net on top of the right side of her head, a 2-inch diameter hair net on top of the left side of her head, and the front sides and back of her hair was loose and not covered inside of the two hair nets. She stated she forgot to put on another hairnet because she ran outside and rushed to start preparing the resident's meal trays. She stated she would go downstairs later after she finished making the resident's plates to get another hair net. In an interview on 05/22/24 at 3:06 pm, Dietary Aide H stated Dietary Aide G left for the day. She stated she used two hairnets to prevent her hair from going into the resident's food. She stated she last had training on use of hair restraints about two months ago and added DD ensured they had their hairnets on properly. She stated they had enough hair nets that were located on the right side, kitchen entrance. She stated they had extra hair nets in the storage unit next to the kitchen/dining area. She stated not wearing a hairnet, could make the resident complain and want another plate. She stated they might get disgusted and make them emotionally upset and lose their appetite. In an interview on 05/22/24 at 3:20 pm, [NAME] I stated the importance of having hairnets kept the food sanitary and hair from getting into the food, drinks, silverware, and wherever the food was prepared. She stated she always wore a hairnet in the kitchen, when preparing the resident's meals. She stated the last hair net training was about a month or two months ago. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/22/24 at 6:48 pm, the DD stated that whenever the dietary staff prepared the meals, they must wear hair nets to help protect the food from being contaminated by their hair falling in it. She stated she had to remind her staff about hair net usage and made sure their hair was tucked in. She stated Dietary Aide G wore 3 hair nets and was not aware she was not ensuring all of her hair was in the hair nets. She stated she would address the matter with Dietary Aide G tomorrow morning. She stated if residents were to find hair in their food it could probably put the residents off from eating and upset them. She stated she had no complaints about hair in food/drinks and she had enough hairnets and the white cap hair nets. She stated her expectations were for all employees to be in compliance with their hair net policy and added the last hairnet training she could not remember but it was early this year. She stated she was going to educate staff tomorrow about hair restraints. In an interview on 05/22/24 at 7:43 pm, Administrator B stated she was not aware of any issues with staff not wearing hairnets when preparing the residents meal plates. She stated her expectations for hair net usage was for all of their hair to be inside of their hairnets. She stated the DD was responsible for ensuring the staff wore hairnets. Record review of the facility's Employee Infection Control: Nutrition Services revised February 6, 2024, revealed, Policy: All local, state, and federal standards, and regulations are followed to ensure a safe and sanitary Nutritional Services Department .Procedure .5. Anyone who enters the kitchen will have all hair restrained using bouffant caps, mesh or net beard guard, and clothing which covers body hair. 10. In addition to standard precautions listed (1-9), employees use these procedures when providing meal delivery using the mobile hot food cart:. Record review of the Federal Food Code dated 2022 reflected: 2-402.11 Effectiveness. (Hair Restraints) 1. Code of Federal Regulations, Title 21, Sections 110.10 Personnel. (b) (1) Wearing outer garments suitable to the operation (4) Removing all unsecured jewelry (6) Wearing, where appropriate, in an effective manner, hair nets, head bands, caps, beard covers, or other effective hair restraints.(8) Confining .eating food, chewing gum, drinking beverages, or using tobacco and (9) Taking other necessary precautions

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on interviews and record review the facility failed to maintain an effective pest control program so that the facility was free of pests of 1 floor (600 floor) of six floors reviewed for effective Pest control. The facility failed to have an effective pest control treatment plan, subsequently, Residents #4 had a reported bed bug in his room on 05/01/24 and Resident #5 had a bed bug report in his room on 05/19/24. The facility failed to follow their Beg bug policy and take actions to eliminate bed bugs reported in two resident's rooms and check all rooms on the 600-hall floor for bed bugs and train all staff on bed bug prevention. These failures could place residents at risk of bed bug bites and skin infections causing allergic reactions, scratch marks and skin tears, which could result in pain and decreased quality of life and psycho-social well-being. Findings included: Record Review of Resident #4's Admission MDS assessment dated [DATE] revealed a [AGE] year-old male who admitted [DATE] with a BIMS Score of 15 (No cognitive impairment). And substantial/maximal assist with moving from left to right, dependent with transfers, toileting and dressing and used a wheelchair. He was diagnosed with medically complex conditions: diabetes, hemiplegia or hemiparesis, asthma, Chronic obstructive Pulmonary Disease or chronic lung disease and respiratory failure. He was diagnosed with ESRD and getting dialysis treatments and had no skin issues and used a pressure reducing device for his bed. Record review of Resident #5's Admission MDS assessment dated [DATE] revealed an [AGE] year-old male who admitted [DATE] with a BIMS score of 13 (No cognitive impairment). And substantial/maximal assistance with showers and dependent lower body dressing and putting on/taking off footwear and used a walker. He was diagnosed with medically complex conditions: heart failure, hypertension (high blood pressure), benign prostatic hyperplasia. He had no skin issues. Record review of the facility's Pest Control sighting log sheet dated 05/01/24 logged by Central Supply Director revealed, Type of pest: Bed bug and location found in Resident #4's room. Record review of the facility's Pest Control sighting log sheet dated 05/23/24 [sic] logged by Maintenance Director revealed, Type of pest: Bed Bug and location found in Resident #5's room. Record review of the Pest Control Treatments invoices revealed bed bug treatments were done to several rooms of the building on 01/19/24, 01/26/24, 02/02/24, 02/16/24, 02/23/24, 03/01/24, 03/18/24, 03/15/24, 03/22/24, 03/29/24, 04/05/24, 04/08/24, 04/11/24, 04/26/24, 05/02/24, 05/09/24, 05/16/24, and 05/23/24. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Pest Control Treatment invoice on 05/02/24 revealed a bed bug treatment was done in Resident #4's room on the 600 floor. Record review of the Pest Control Treatment invoice on 05/23/24 revealed a bed bug treatment was done in Resident #5's room on the 600 floor. In an interview on 05/21/24 at 9:45 am, Former Administrator C stated they currently had an ALF resident, Resident #5 who went to the hospital and readmitted to their Skilled Nursing floor 600. He stated after this resident readmitted to the Skilled Nursing floor he went to his Apartment on the 500 floor to get some of his personal items. He stated they suspect the bed bugs came from the clothes he took from his ALF apartment which had been treated for bed bugs in the past. He stated after the bed bugs were reported, the Maintenance Director did a bed bug chemical treatment. He stated the Pest Control Provider would be coming out 05/23/24 to do a bed bug treatment of the whole 600 floor. He stated this was the first time there was any mention of bed bugs on the 600 floor. He stated once a report of bed bugs was done, they notified all the department heads. He added now their Pest Control Provider came to do bed bug treatments every Thursday and spent the whole day doing the treatments. He stated their Pest Control Provider also came on off days for special requests. He stated they changed out their Pest Control Tech that did their past bed bug treatments and the Pest Control management team was also coming out as a level of oversight. He stated they had pest control provider contracts they were reviewing and may change pest control providers soon. He stated there was no other rooms affected by the bed bugs and there had not been any activity since the initial sighting last Sunday (05/19/24). He stated after the bed bug sighting, he did a Bed Bug prevention training with the staff. In an interview on 05/21/24 at 4:30 pm, Resident #4 stated he was lying in the bed watching television on 05/01/24 and saw one bed bug crawling across the top of his bed sheet. He stated he told one of the staff and she said she would report it, then the Maintenance Director came and spray treated his room, and nurse checked him out. He stated he had no skin issues, no bite marks, and had not seen any more since then but last Sunday (05/19/24) the staff were all suited up going to a room down the hall. He stated he asked what was going on and the staff said that a room was being sprayed for bed bugs then the Maintenance Director came in to spray his room too. In an interview on 05/22/24 at 10:30 am CNA J stated she had not had any pest control trainings and was not aware the nursing home floor had bed bugs. She stated this was her first-time hearing about this. In an interview on 05/22/24 at 10:41 am, the ADON stated she worked last Saturday (05/18/24) and on Monday (05/20/24) she heard about the bed bug sighting in Resident #5's room. She stated she suspected Resident #5's clothes had bed bugs on them because Resident #5 had a bed bug on their bed sheet. She stated she had not seen any bed bugs and the last bed bug training was last month (April 2024). (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/22/24 at 11:00 am, Resident #5 stated his ALF apartment had bed bugs and it had been spray treated three times in the past. He stated he had turned blue in the face asking to get that room sprayed for bed bugs. He stated he went to the hospital and afterwards went to the 600 floor skilled unit at this facility for rehabilitation and needed some clothes, so he went down to his apartment on another floor and got them. He stated now the staff were telling him he brought bed bugs up to his new room on the 600 floor. He stated the staff took all of his clothes and washed them and bed bug sprayed this room on the 600 floor. He stated being assessed by the nurse and not being bitten. In an interview on 05/22/24 at 11:58 am, Administrator B stated this was her second day working as this Administrator and she found out about the bed bug issue on the 600 floor yesterday 05/21/24. She stated she was not sure who the resident was but was told the 600 floor normally did not have any bed bugs. She stated she heard ALF Resident #5 was transferred to the 600 floor and brought the bed bugs with him. She stated pest control spray treated and inspected the facility every Thursday. She stated the department heads and herself had a meeting yesterday to discuss the bed bug issue. She started asking the team how long they have had the bed bug issue and was told it had been a while and was told what they did in the past. She stated telling them the pest control plan was not working and wondered what else could be done. She stated she questioned was it also a housekeeping issue, and suggested they needed to make sure they had one vacuum cleaner per floor. She stated she noticed some housekeeping issues of the facility not being as clean as it should be. She stated the Housekeeping Director was in the process of getting more training on how to clean the facility better and with power washing the wheelchairs. She stated she reviewed the pest control contract to see if they had a bed bug program because their Pest Control Provider needed to do something so that this could be resolved. She stated she was working on getting shoe booties and added she was having a meeting with all of the residents this Friday about the bed bug issue. She stated right now she will start doing staff trainings for them to be able to identify what bed bugs were and if they saw them who they needed to report to and what documents to complete, and skin assessments need to be completed. She stated she was going to have an AD HOC QAPI (Quality Assurance) meeting with the whole management team and the Medical Director to address this issue. She stated she spoke to the corporate office about changing pest control providers if the current pest control provider was not able to resolve this issue. She stated she was told the bed beg sighting in Resident #5's room was isolated and only happened once on the 600 floor. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/22/24 at 1:34 pm, the Central supply Director stated the 600 floor did not usually have any bed bug issues. She stated the only problem was when an ALF Resident transferred to the hospital and returned to the 600 skilled nursing floor. She stated there were bed bugs in Resident #5's ALF room and when he went to get his wheelchair or rolling walker and clothes, they took the bed bugs to the 600 hall. She stated they had three bed bug sightings she heard about on the 600-hall floor. The first time was earlier this year, two months ago, and then last Sunday (05/19/24). She stated she never saw bed bugs and did not see any on 05/01/24 and last Sunday 05/19/24. She stated pest control came out regularly and on Sunday 05/19/24, after the report on Resident #5, he was showered and his clothes were washed. She stated they changed his mattress and did a bed bug spray treatment in that room and the surrounding rooms. She stated they had bed bug trainings every day and the last time was yesterday by the DON and today by the Maintenance Director and Administrator B. She stated around 11:00 am today, Pest Control did spray treatments on the 600 floor, and added the bed bug issue was not as bad now. She stated they needed to continue to check the resident's belongings to ensure they had no bed bugs. She stated Resident #4 might have said something about seeing a bed bug on 05/01/24 to her and she put it in the logbook. She stated then the Maintenance Director went and treated Resident #4's room and was not sure if she reported the bed bug sighting to the DON, Administrator C, or resident #4's nurse. She stated she did not bother Administrator C unless it was something serious. She stated bed bugs could bite the residents, leave bitemarks on their skin, and could make them sick. Interview on 05/22/24 at 2:36 pm, Administrator C stated yes there was a bed bug reported in Resident #4's room on 05/01/24 and could not remember all they did and did not have any documentation to provide. In an interview on 05/22/24 at 3:39 pm, Medication Aide M stated last Saturday (05/18/24) night around 10:00 pm, she saw one bed bug in the elevator crawling on the floor when she was going to the 600 floor. She stated Sunday (05/19/24) around 10:00 am she saw one bed bug crawling on Resident #5's bed spread. then she notified LVN O, then the Maintenance Director came in, cleaned the room, and removed the mattress. She stated she saw the Maintenance Director do a spray treatment in Resident #5's room . She stated she had not seen any other bed bugs on the 600 hall. She stated after seeing the bed bugs, she reported it to Administrator C. She stated she had not had any bed bug prevention training since this happened last weekend, and she was not able to recall the last time she had one. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/22/24 at 3:59 pm, the Maintenance Director stated he was not sure how long there had been a bed bug issue at this building but was warned about it before he started working here. He stated he was open to doing what was needed to get rid of the bed bugs. He stated when he first started working here the bed bugs were all over the place and Pest Control started using a new chemical to kill them, but they still had bed bugs in this building. He stated speaking to the Pest Control Regional Director they were put on a 90-day plan to get rid of the bed bugs. He stated he requested the previous pest control guy not come back because he was not thorough enough and did not let them know if a room did not get treated. He stated the Pest Control company came out now every Thursday and spray treated and inspected all of the rooms. He stated he also heat treated the rooms in between the Pest Control's visits. He stated they normally did not have any bed bugs on the 600 floor but last Sunday (05/19/24) he was called out to address a bed bug issue on the 600 floor. He stated he did not see any bed bugs, but they treated Resident #5's room as a precaution. He stated he saw bed bugs in some of the ALF rooms in the past, but not on the 600 floor. He stated the Pest Control company had a bed bug free guarantee plan that would cost an additional $200.00 more and was not sure on the status of getting that plan. He stated what could have caused the bed bugs to spread was when ALF residents went to the 600 floor to visit nursing home residents. And the other way was when ALF residents moved up to the SNF 600 floor for rehabilitation services and brought their belongings with them. He stated the last bed bug staff training was last Sunday (05/19/24) and today (05/22/24). He stated it was a staff member, who saw the bed bug on Resident #5's bed sheet. He stated he was currently in the process of educating the alert residents what bed bugs were and today (05/22/24) they did a full inspection of the 600 hall and they did not see any more bed bugs on that floor. He stated having bed bugs could result in the staff not wanting to work at this facility. In an interview on 05/22/24 at 5:46 pm, the DON stated having bed bugs on the 600 floor was new. She stated when ALF residents with bed bugs brought their belongings from their rooms to the 600 floor was the problem . She stated the Housekeeping and Maintenance Directors should be responsible for ensuring the facilty had no bed bugs. She stated it was a team effort from everyone to notify housekeeping, Maintenance, and the Administrator and herself to properly handle the situation. She stated bed bugs could cause residents to itch, lead up to an infection, and cause them pain from scratching. She stated Residents #4 and #5 incident reports were completed and they had no adverse affects. In an interview on 06/22/24 at 5:58 pm, LVN O stated she worked last Sunday (05/19/24) and MA M told her she saw a bed bug on Resident #5's bed sheet in his room. She stated it was suspected that Resident #5 took belongings from his ALF apartment to get some pants and socks. She stated the Maintenance Director came and spray treated and Resident #5 was showered, and that mattress was removed. She stated she did not know she had to do an incident report on Resident #5 because nobody told her to do one. She stated she did a skin assessment and notified Resident #5's doctor. She stated she did not see any bed bugs in the room or on the resident. She stated they checked the other residents, and none were affected. She stated she had not had a bed bug prevention training. In an interview on 05/22/24 at 10:52 am, Former Administrator C stated the bed bug report in Resident #4's room on 05/01/24 he believed was a false report, because they inspected it and they did not see any bed bugs. He stated he was not sure if Resident #4 had a skin assessment but he should have had one. He stated he would have to check and go back and review the policy on that. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/23/24 at 11:03 am, the Facility's Ombudsman stated this facility has had problems with bed bugs for a while. She stated the facility changed the Pest Control Tech and now had two pest control Techs doing treatments at the facility. She stated she spoke to Administrator C and he would tell her they were working on it and had Pest control spray treating the facility every Friday. She stated she was not sure if they were using the right type of solution to address the bed bugs because what they were using was not killing them. She stated on 04/11/24 she was supposed to have a meeting with the Maintenance Director, the Maintenance Assistant, and the Pest Control Representative but the meeting was missed, and she had no response from the facility on rescheduling. She stated an EMT provider contacted them about the bed bug issue and concern of their paramedics getting bed bugs from going to the resident's rooms to take them to the hospital. She stated she was talking to upper management on what they could do to assist the facility. Record review of Article https://www.mayoclinic.org/diseases-conditions/bedbugs/symptoms-causes/syc-20370001 dated 01/05/24, revealed, Bedbugs: Overview .Bedbugs are small, reddish-brown blood-sucking, wingless insects. Bedbug bites usually clear up without treatment in a week or two. Bedbugs aren't known to spread disease, but they can cause an allergic reaction or a severe skin reaction in some people. Bedbugs are about the size of an apple seed. They hide in the cracks and crevices of beds, box springs, headboards, bed frames, and other objects around a bed and come out at night to feed on their preferred host, humans. The risk of running into bedbugs is higher if you spend time in places where nighttime guests come and go often - such as hotels, hospitals, or homeless shelters. If you have bedbugs in your home, professional extermination is recommended .Symptoms: Symptoms of bedbug bites are similar to symptoms of other insect bites and rashes. Bedbug bites are usually: Inflamed spots, often with a darker spot in the middle Itchy, Arranged in a rough line or in a cluster, Located on the face, neck, arms, and hands, Some people have no reaction to bedbug bites, while others experience an allergic reaction that can include severe itching, blisters, or hives .When to see a doctor: If you experience allergic reactions or severe skin reactions to bedbug bites, see your health care provider for professional treatment. Record review Facility's Pest control policy dated December 2018 revealed, Form(s): Beg bug identification, bed bug management plan, bed bug toolkit, Policy: The facility will take actions to eliminate bed bugs identified in the resident room .Procedures I. Identification A. Train housekeeping and direct staff on identification of bed bugs .B. Inspect all upholstered furniture prior to it [sic] entering the resident's room .C. If bed bugs found in a room, all rooms should be checked for bed bugs. Visual sweep includes: 1. Mattress 2. Headboards 3. Behind picture walls 4. Carpet edging 5. Pillows 6. Upholstered furniture .D. Check residents for rash and bitemarks. II. Known infestation (visually have seen bed bugs in room) A. Upon realization that a resident's room has had bed bugs, attending personnel will immediately notify the Administrator and Director of Nursing Record review of the Facility's Bed Bug policy undated revealed, Policy Statement: Our facility shall maintain an effective pest control program .Policy Interpretation and Implementation .1. The facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents .6. Maintenance services assist, when appropriately and necessary, in providing pest control.