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	12/05/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, which includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 1 resident (Resident #2), reviewed for care plan development. The facility failed to ensure Resident #2's comprehensive care plan included a plan of care for ADLs. This failure could place residents at risk of not receiving care and services to meet their needs, diminished function of health, and regressions in their overall health.Record review of a face sheet dated 10/14/25 revealed Resident #2 was 90-years-old and was admitted on [DATE] with diagnoses including other idiopathic peripheral autonomic neuropathy (damage to the nerves that control involuntary bodily functions), depression (mental health condition), secondary hypertension (high blood pressure), unspecified atrial fibrillation (an irregular rapid heart rate), and chronic diastolic congestive heart failure (the heart muscle is unable to relax properly). Record review of the most recent MDS dated [DATE] indicated Resident #2 was cognitively intact with a BIMS score of 15. Section GG (Functional Abilities) reflected Resident #2 required substantial/maximal assistance for toileting hygiene, shower/bathe self, partial/moderate assistance with upper body dressing and set up or clean up assistance with eating and oral hygiene. Record review of Resident #2's care plan last reviewed 09/08/25 revealed there was no plan of care that identified measurable objectives, goals, interventions and timeframes for ADLs. During an interview on 10/15/25 at 12:59 p.m., the Administrator stated the care plan told a story about the resident's care and preferences. The Administrator stated that without ADLs listed in the care plan, the staff won't know what the residents like. The Administrator stated the MDS nurse was responsible for the comprehensive care plan. During an interview on 10/15/25 at 1:53 p.m., the DON stated every resident should have a plan of care that reflected their likes, dislikes, everyday routine, and anything that affected the residents. She stated the absence of ADLs in the care plan diminished staff communication and knowledge of resident preferences. She stated she was unsure why ADLs were not included in the care plan. She stated the MDS Coordinator was responsible for writing the care plans. During an interview on 10/15/25 at 01:43 p. m., the MDS Nurse stated she was responsible for updating the care plan. She stated the care plan reflected a picture of the resident's functioning, preferences, and how much assistance was needed to meet their needs. She stated it was important to have an accurate care plan because it reflected the resident's level and any improvement. Record review of the facility Care Plan-Process policy last revised on 02/12/20 and reviewed 03/27/23 revealed: The interdisciplinary team will coordinate with the resident and their legal representative an appropriate care plan for the resident's needs or wishes based on the assessment and reassessment process within the required time frames. 4) Interdisciplinary Team meets and reviews the care plan as follows: Quarterly and annually 5) The team directs care planning toward attaining and maintaining the highest optimal physical, psychosocial, functional status including Advance Directives, and signs the approved plan of care.

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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** Based on interview and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one of five residents reviewed for catheter and incontinence care. The facility failed to ensure CNA G provided timely incontinence care for Resident #2 on 10/14/25. This failure could place residents at risk for not receiving appropriate care to address their incontinence and could increase the risk of urinary tract infectionRecord review of a face sheet dated 10/14/25 revealed Resident #2 was a [AGE] year-old female who was admitted on [DATE]. Resident #2 had a BIMs score of 15, which indicated she was cognitively intact. Resident #2's diagnoses included other idiopathic peripheral autonomic neuropathy (damage to the nerves that control involuntary bodily functions), depression (mental health condition), secondary hypertension (high blood pressure), unspecified atrial fibrillation (an irregular rapid heart rate), and chronic diastolic congestive heart failure (the heart muscle is unable to relax properly). Record review of Resident #2's most recent MDS dated [DATE] indicated: Section H (Bladder and Bowel): H0300-Urinary Continence reflected Frequently incontinent. H0400-Bowel Continence reflected Frequently Incontinent. An interview with Resident #2 on 10/14/25 at 10:50am revealed she had not had a diaper change all morning. Resident #2 stated her call light had not worked for 2 months but she had a bell to alert staff. An interview with CNA G on 10/14/25 at 10:58am revealed Resident #2 was not changed since her shift began at 6:00am. CNA G stated she had to get 4 to 5 residents up for breakfast when she arrived for her shift and another resident needed a shower. CNA G stated she was responsible for 16 residents this day. CNA G stated incontinent care was expected to be provided every 2 hours or when requested. CNA G stated incontinent care delay resulted in skin breakdown or rawness for the resident. An interview with LVN K on 10/14/25 at 11:59am revealed residents were expected to be changed every 2 hours or when needed. LVN K stated delayed incontinent care caused skin breakdown or depression. An interview with the DON on 10/15/25 at 1:53pm revealed the expectation for incontinence care was every two hours for residents or when the call light was pressed for care. The DON stated the risk of incontinent care delay was potential infection, UTIs, and skin breakdown. Record review of the facility's policy titled, Perineal Care/Incontinent Care effective April 2012, reflected, staff will perform perineal/incontinent care with each bath and after each incontinent episode.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one resident (Resident #1) reviewed for catheter care. The facility failed to ensure CNA C maintained Resident #1's indwelling urinary catheter (a tube that drains urine from the bladder) drainage bag below the bladder level during transfer from bed to Geri-Chair (a supportive, reclining chair designed for individuals with limited mobility, offering more comfort and stability than a traditional wheelchair) on 10/15/25. This failure placed residents at risk for infection. A record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including obstructive uropathy (a condition where urine flow is blocked, leading to the accumulation of urine in the urinary tract), and cancer (a group of diseases characterized by uncontrolled cell growth and the ability to invade and spread to other parts of the body). Resident #1 had a BIMS score of 09 which indicated Resident #1's cognition was moderately impaired. He required extensive assistance of two-person physical assistance with bed mobility and transfer. Resident #1 had an indwelling catheter. Record review of Resident #1's care plan dated 06/26/25 reflected, Problem: Urinary catheter (SUPRAPUBIC) . Goal: Resident will be free of complications of indwelling catheter . Interventions: . Complications can include an increased risk of urinary tract infection, blockage of the catheter with associated bypassing of urine, expulsion of the catheter . Observation on 10/15/25 at 07:38 AM revealed CNA C, CNA E were in the process of getting Resident #1 transferred from bed to Geri chair. CNA C unhooked the catheter bag from the bed rail. CNA C put the catheter bag flat on the foot of the bed, above the resident's bladder. CNA C and CNA E hooked the transfer sling to the Mechanical left. CNA C took the foley catheter bag and hung it to the shaft of the Mechanical left. The two CNAs maneuvered the mechanical left and get Resident#1 on the Geri chair. During the procedure urine was observed flowing back toward the resident's bladder. After lowering Resident#1 to the Geri chair, CNA C hooked the catheter bag onto the Geri chair frame. In an interview with CNA C on 10/15/25 at 07:55 AM, she stated she was trained to always keep the catheter drainage bag below the bladder. She stated she put the bag on the bed to prevent it from pulling. She stated having it above the bladder could possibility cause the urine to run backwards, which could cause an infection. In an interview with the Administrator on 10/15/25 at 12:58 PM she stated her expectations were for the staff not to put the foley catheter bag on the bed because the flow could go back and cause the Resident to develop infection. In an interview with the DON on 10/15/25 at 2:13 PM she stated any resident with a foley catheter should always have the bag and tubing below the bladder. She stated not keeping the foley catheter bag below the resident's bladder, placed them at risk of urinary tract infection and cross contamination. Review of the facility's policy titled, Care and Removal of an Indwelling Catheter, revised 01/12/2020 did not address the concern.

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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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 and to help prevent the development and transmission of communicable diseases and infections for two (Resident #1, and Resident#3) of two residents observed for infection control during incontinent care. 1-The facility failed to ensure LVN A, CNA C, CNA D, CNA E wear proper PPE while caring for Resident#1 in EBP Isolation. 2-The facility failed to ensure CNA F performed hand hygiene between glove changes, and LVN B did not put the dirty linen on the floor while providing incontinent care to Resident #3. These failures could place residents at risk for spread of infection through cross-contamination.1- A record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected Resident #1 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including obstructive uropathy (a condition where urine flow is blocked, leading to the accumulation of urine in the urinary tract), and cancer (a group of diseases characterized by uncontrolled cell growth and the ability to invade and spread to other parts of the body). Resident #1 had a BIMS score of 09 which indicated Resident #1's cognition was moderately impaired. He required extensive assistance of two-person physical assistance with bed mobility and transfer. Resident #1 had a supra pubis catheter (a urinary drainage tube inserted through a small incision in the lower abdomen, just above the pubic bone, into the bladder). Record review of Resident #1's care plan dated 06/26/25 reflected, Problem: Enhanced Barrier Precautions related to suprapubic catheter and wounds. Goal: Prevent/manage the likelihood of complications due to isolation over the next 90 days. Interventions: Contact Isolation Precautions are to be used during all aspects of care. handwashing Educate resident and family members on standard precautions and the importance of.Observation on 10/15/25 at 7:38 AM revealed LVN A was in the process of changing the nephrostomy (a surgical procedure that creates a temporary or permanent opening in the kidney to drain urine directly into a collection bag) exit site dressing, and supra-pubic catheter exit site dressing for Resident#1 with gloved hands and without wearing a gown. CNA C with gloved hands, and without wearing a gown was providing Resident#1 morning care and got him ready to sit in a Geri-chair (a supportive, reclining chair designed for individuals with limited mobility, offering more comfort and stability than a traditional wheelchair). CNA E entered Resident#1's room, washed hands, put on clean gloves, but she did not put on a gown. CNA E proceeded to help CNA C put resident lift sling under Resident#1. CNA D got the Geri-chair and the Mechanical lift and entered Resident#1's room.She washed her hands, put on clean gloves but did not put on a gown. The three CNAs maneuvered the Mechanical left, the Geri chair, and put Resident#1 on the Geri chair. The three CNAs removed gloves, washed hands and exited the room. There was a PPE supplies cart in front of the room, but no EBP isolation signage.In an interview on 10/15/25 at 07:45 AM, LVN A stated she was supposed to wear a gown while performing high contact procedure with Resident#1 who was in EBP isolation. She stated, she was about to go home at the end of her night shift, when she found out that Resident#1 had to get up and ready for a doctor appointment. She stated she was in rush and forgot to put on proper PPE (gloves and gown). She stated the risk spread of infection.In an interview on 10/15/25 at 07:55 AM, CNA C stated she did not know that she supposed to wear gown while performing morning care for Resident#1. She stated she saw the supplies cart in front of the room but did not know what it was for. She stated the risk spread of infection.In an interview on 10/15/25 at 08:12 AM, CNA D stated she did not know that she supposed to wear gown while helping with Resident#1's transfer. She stated she saw the supplies cart in front of the room but did not know what it was for. She stated the risk spread of infection.In an interview on 10/15/25 at 10:22 AM, CNA E stated she was supposed to wear gown while helping to get Resident#1 up in his Geri chair. When asked how she knew Resident#1 was in EBP isolation, she replied by the PPE supply cart in front of the resident's room, and the name of the resident written on blue paper vs the white paper for non-isolation residents. She stated the risk would be the spread of infection. 2-Review of Resident #3's quarterly MDS assessment, dated 07/04/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE], with the following diagnoses: type 2 diabetes, hypertension, morbid obesity due to excess calories. Review cognitive patterns reflected a BIMS of 15, which meant Resident #3's cognition was intact.Observation on 10/15/25 at 11:51 AM revealed CNA F with the help of LVN B entered Resident#3's room to do incontinence care. CNA F washed her hands using soap and water and donned clean gloves. LVN B washed hands and put on clean gloves. CNA F unfastened the resident's