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	02/13/2025

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560 Based on interview and record review, the facility failed to ensure a discharge MDS was electronically completed and transmitted to the CMS System within 14 days after completion for two (Resident #23 and Resident #43) of two residents reviewed for discharge assessments. The facility failed to complete and transmit Resident #23's and Resident #43's discharge MDS assessment within 14 days of completion. This failure could place the residents at risk of having incomplete records. Findings include: Review of Resident #23's face sheet, dated 02/13/25, reflected Resident #23 was an [AGE] year-old female admitted to the facility on [DATE]. Review of Resident #23's facility death record, dated 02/13/25, reflected Resident #23 date of death [DATE]. Review of Resident #23's MDS assessments on 02/12/25 revealed Resident #23 did not have a discharge MDS assessment completed. This MDS record was identified as greater than 120 days late on the resident assessment facility task. Review of Resident #43's face sheet dated 02/13/25 reflected Resident #43 was a [AGE] year-old male admitted to the facility on [DATE]. Review of Resident #43's Against Medical Advice form dated 09/30/24, reflected Resident #43 discharged on [DATE]. Review of Resident #43's MDS assessments on 02/12/25 revealed Resident #43 did not have a discharge MDS assessment completed. This MDS record was identified as greater than 120 days late on the resident assessment facility task. (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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/13/25 10:21 AM with MDS Nurse F revealed Resident #23 and Resident #43 should have had discharge assessments. She stated that they had a change in the electronic health record system in November 2024 and was unable to see previous assessments. She stated that she was responsible for completing all MDS assessments. She stated the transmission of MDS assessment to CMS was conducted by the Regional MDS coordinator. She stated the timeframe for completing and transmitting discharge assessments was within 14 days of discharge or death. In a phone interview on 02/13/25 11:49 AM with the Regional MDS RN stated that all discharge or death assessment should be completed and transmitted to CMS within 14 days of discharge or death. She stated that Resident #23 had Quarterly MDS assessment dated [DATE] and Resident #43 had Admission MDS assessment dated [DATE] in the EHR. She stated that she could not find any discharge MDS assessment for Resident #23 and Resident #43 either in the previous or new EHR nor could she find MDS transmission records for the same. She stated that facility MDS nurse was responsible for completing all MDS assessment in timely manner. She stated she will contact the MDS Nurse F in the facility to complete MDS assessments for Resident #23 and Resident #43 after the interview. In an interview on 02/13/25 12:39 PM with the Administrator stated that Facility MDS Nurse was responsible for completing all MDS assessment in timely manner and it was her expectation that all the MDS assessments were completed and transmitted to CMS within the stipulated time frame. She stated that failure to do so will lead to CMS not being aware if the resident was still residing in the facility. Review of facility's policy titled Resident Assessment revised on January 12, 2020 reflected, . It is the Standard of Care at this facility to conduct, initially and periodically, a comprehensive, accurate assessment of each resident's functional capacity utilizing the Minimum Data Set (MDS) according to the guidelines set forth in the Resident Assessment Instrument (RAI) manual .Comprehensive assessments will be completed not less often than once every 12 months (366 days), within 14 calendar days after admission, or within 14 days of a significant change determination . Tracking records and OBRA assessments will be transmitted electronically, in a CMS specified format, within 14 days of the assessment completion. MDS transmission Validation Reports will be saved electronically.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49640 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 24 residents (Resident #1), reviewed for care plan development. The facility failed to ensure Resident #1's comprehensive care plan included a plan of care for dialysis. This failure could place residents at risk for not receiving care and services to meet their needs, diminished function of health, and regressions in their overall health. The findings included: Record review of a face sheet dated 02/12/25 revealed Resident #1 was an [AGE] year-old male and was admitted on [DATE] with diagnoses including peripheral vascular disease (a circulatory condition), hypotension of hemodialysis (occurs when a large amount of blood is rapidly filtered during dialysis), muscle wasting and atrophy (a decrease in muscle mass and strength), and enterocolitis due to clostridium difficile (inflammation of the intestines). Record review of the most recent MDS dated [DATE] indicated Resident#1 was cognitively intact with a BIMS score of 15. Record review of Resident #1's care plan initially reviewed on 01/22/25 at 10:45 an revealed dialysis was not addressed in the plan of care prior to entry date of survey date (02/11/25) and time (9:08am). Record review of Resident #1's physician order summary revealed an order with a start date of 01/23/25 for Dialysis, M-W-F. During an interview on 02/13/25 at 8:50 a.m., the DON stated the resident was admitted to the facility as a dialysis patient. The DON stated every resident should have a plan of care. The DON stated anything that affected the resident should be care planned. She stated she was unsure why dialysis was not care planned prior to 02/11/25. She stated the MDS Coordinator was responsible for writing the care plans. During an interview on 02/13/25 at 01:48 p.m., the MDS Coordinator stated she did not see the plan of care addressed dialysis. She stated although there was a new system, it was already in effect when the resident was admitted . She stated she usually care planned the physician orders. She stated it was important to have an accurate care plan because it reflected what the facility was doing for the patient. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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

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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** 48560 Based on observations, interviews, and record review the facility failed to provide the necessary services for residents who were unable to carry out activities of daily living to maintain good grooming and personal hygiene for 2 residents (Resident #30 and Resident #19) of 5 residents reviewed for ADLs. The facility failed to ensure Resident #30, and Resident #19 had their fingernails cleaned and trimmed on 2/11/25. These failures could place residents at risk for loss of dignity, risk for infections, and a decreased quality of life. Findings included: 1- Resident #30 Record review of Resident #30's Quarterly MDS assessment dated [DATE] reflected Resident #30 was [AGE] year-old male with initial admitted to the facility of 02/28/2024. His diagnoses included stroke (interrupted blood flow to the brain leading to partial or complete brain damage), hypertension (high blood pressure), hyperlipidemia (high lipid levels), and anxiety. Resident #30 had BIMS of 15 which indicated Resident #30 had intact cognition. Resident #30 was totally dependent on staff for personal hygiene. Record review of Resident #30's Comprehensive Care Plan revised on 11/03/2024 reflected, .Problem: Fall Risk related to amputation. Intervention: . Assist [Resident#30] with ADLs as needed . In an observation and interview on 02/11/25 at 11:37 AM revealed Resident #30 had dirty and jagged nails. The nails on both hands were approximately 0.4 cm in length extending from the tip of his fingers. Resident #30 stated he would like his nails to be clipped and cleaned. He stated that he was dependent on staff for nailcare, and he did not have clippers to cut his nails. 2- Resident #19 Record review of Resident #19's Quarterly MDS assessment dated [DATE] reflected Resident #19 was [AGE] year-old male with initial admitted to the facility of 03/20/2019. His diagnoses included Fractures and other multiple traumas, Hypertension (high blood pressure), Peripheral vascular disease (decreased blood flow to the limbs), hyperlipidemia (high lipid levels), Schizophrenia (chronic mental condition affecting the thought process and perceptions). Resident #19 had BIMS of 15 which indicated Resident #15 had intact cognition. Resident #19 needed moderate assistance for personal hygiene. Record review of Resident #19's Comprehensive Care Plan revised on 11/13/2024 reflected, , .Problem: Fall Risk (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	related to history of peripheral vascular disease. Intervention: . Assist [Resident#19] with ADLs as needed . In an observation and interview on 02/11/25 12:07 PM revealed Resident #19 sitting in the dining room. Resident #19 had long, jagged nails with black discoloration underneath the nailbed. The nails on both hands were approximately 0.3 cm in length extending from the tip of his fingers. Resident #19 stated that he could use help to cut nails. He also stated that the staff have clippers, and they clip his nails, however his nails had not been clipped for several days. In an observation and interview on 02/11/25 02:21 with CNA H stated CNAs and Nurses were responsible for nailcare. She stated nail care was performed on shower days and as needed. She said if a resident had diabetes, then nurses trimmed their fingernails. She stated that if nails were long and dirty, residents may be at risk of infection. She added Resident #30 refused nail care at times. She stated if ADLs were refused, she informed the Charge Nurse about refusals. CNA H then approached Resident #30 in the activity area and asked if he would like his nails cleaned and trimmed after he was done with the activities. Resident #30 stated he would like them to be clipped. In an interview and on 02/11/25 02:43 PM with RN G stated that both nurses and CNAs were responsible for doing nail care for the residents. She stated that fingernails should be trimmed and cleaned on shower days and as needed. She stated that dirty, jagged nails could lead to risk of increased infections. In an interview on 02/11/25 03:01 PM with the DON she stated nail care was the responsibility of all CNAs and Nurses. The DON stated nails should be observed daily. The DON stated she expected CNAs to offer to cut and clean nails if they were long and dirty. The DON stated she and management personnel conducted routine rounds to monitor ADL care. The DON stated residents having long and dirty could cause skin integrity to be broken and cause bleeding or infection. Record review of the facility policy titled, Bathing (not partial or complete bed bath) dated February 12, 2020, reflected, Nail care is given to clean and keep the nails trimmed . o Perform hand hygiene and perform nail care

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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** 42971 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 of two residents (Resident #12) reviewed for catheter care. The facility failed to ensure CNA C maintained Resident #12's indwelling urinary catheter (a tube that drains urine from the bladder) drainage bag below the bladder level during wound care on 2/11/25. This failure placed residents at risk for infection. Findings included: A record review of Resident #12's Quarterly MDS assessment dated [DATE] reflected Resident #12 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including malignant neoplasm of prostate (a cancerous tumor that starts in the prostate gland), and pressure ulcer of the sacral region (located at the lower end of the spine). Resident #12 had a BIMS score of 15 which indicated Resident #12's cognition was intact. He required extensive assistance of two-person physical assistance with bed mobility and transfer. Resident #12 had an indwelling catheter. Record review of Resident #12's care plan dated 11/14/24 reflected, Problem: Urinary catheter . Goal: Resident will be free of complications of indwelling catheter . Interventions: . Keep catheter tubing placed below level of bladder . Review of Resident #12's Order Summary report dated February 2025, reflected, Suprapubic catheter every shift, continuous gravity drainage and catheter care. Privacy bag checked and placement of leg strap verified every shift. with a start date of 11/11/24. Observation on 02/11/25 at 02:52 PM revealed LVN B entered Resident #12's room to do wound treatment. CNA C entered Resident #12's room to assist LVN B. LVN B unhooked the catheter bag from the bed rail and gave it to CNA C. CNA C put the catheter bag flat on the foot of the bed, above the resident's bladder. LVN B provided wound care to the buttock wound. During the procedure urine was observed flowing back toward the resident's bladder. LVN B finished the treatment and then CNA C gave the catheter bag to the LVN B; LVN B hooked the catheter bag onto the bed rail. In an interview with LVN B on 02/11/25 at 03:20 PM she stated she was focused on the treatment; she did not pay attention that the CNA put the urine bag on the bed. She stated the catheter bag and tubing were supposed to be kept below the bladder. She stated failing to do this could cause the urine to back up and might cause an infection. In an interview with CNA C on 02/11/25 at 03:32 PM, 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. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 02/12/25 at 02:42 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. She stated to ensure staff were knowledgeable in the care of indwelling catheters the facility does skills competency checks and she stated the ADON, and Charge Nurses made daily rounds and watched care. She stated when staff needed to be re-trained, she provided the in-service training. Record review of CNA C's competency check off for catheter care revealed she was proficient in care as of 08/30/24. 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42971 Based on observation, interview and record review the facility failed to label drugs and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date for 1 (nurses cart hall 600 (617 through 631) of 2 medication carts reviewed for labeling of drugs and biologicals in that: The Nurses' Cart on Hall 600 (617 through 631) had 1 insulin pen for Resident #20 with no open date. Observation of the pen reflected it was not full and it was used. This failure placed residents at risk of not receiving the therapeutic benefits of the medications. The Findings included: Observation on 02/11/25 at 10:31 AM of the nurses' cart on hall 600 (617 through 631), with LVN A revealed the pen of insulin Humalog (lispro) 100 unit/ml for Resident #20 with no open date. Observation of the pen reflected it was not full and it was used. Interview on 02/11/25 at 10:35 AM, LVN A stated she gave insulin to Resident #20 in the morning at 7:00 AM and she did not check the pen for the open date. LVN A stated the purpose for putting an open date was for expiration purposes because the insulin was only good for 28 days. She stated after 28 days the insulin would be ineffective. Interview on 02/12/25 at 02:42 PM, the DON stated the insulin flex pens and vial, once opened, needed to be dated because each insulin pen and vial had a specific day's shelf life and if not thrown out by that time the insulin could lose its effectiveness. The DON stated the pharmacy consultant checked the carts monthly and she stated DON and ADON were supposed to do random checks of the medication carts for monitoring. Record review of the facility's policy titled Medications and Medication Labels, dated January 2023, revealed in part .2. Multi-dose vials shall be labeled to assure product integrity, considering the manufacturers' specifications. (Example: Modified expiration dates upon opening the multi-dose vial.) Nursing staff should document the date opened on multi-dose vials .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48560 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 the facility's only kitchen. The facility failed to ensure food items in the facility kitchen had use-by date. This failure could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination. Findings included: In an Observation on 02/11/25 at 10:00 AM of the facility walk in refrigerator revealed two packets of liquid eggs were opened but did not have use by date. In an interview and observation on 2/11/25 10:05 AM with the Dietary Manager revealed liquid egg packets were opened but not dated. She stated that all open items need to have 'open date' and 'used by date' depending on the food item. She stated that liquid eggs were open for breakfast on 2/11/25 and should have had use by date of 2/14/25 since liquid eggs were good for consuming for 3 days after opening. She stated that everyone in the kitchen including Cooks, Dietary aide and herself were responsible for dating food items in the kitchen. She stated risk of not dating was possible risk of food borne illness to the residents. In an interview on 02/12/25 12:07 PM with Dietary Aide E revealed everyone working in the kitchen was responsible for dating open food items. She stated for any food item that was open, it should have an open date and use by or expiry date. She stated risk of not dating food items was possibility of getting residents sick. In an interview on 2/12/25 12:54 PM with [NAME] D revealed everyone in the kitchen was responsible for dating food items. She stated that liquid eggs had use by date of 3 days after opening. She stated that opened, not dated food items posed a risk to residents since kitchen personnel were not sure how long food items have been opened and can make residents sick if they were spoiled. She stated that they received in-services from the Dietary Manager often about dating and labeling food items. Record review of the facility's policy titled, Food Storage policy revised February 6, 2024, reflected, Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination 2. Refrigerator .All foods are covered, labeled, and dated. Defrosting meat, eggs and milk shakes are labeled with date pulled for thawing . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Food and Drug Administration Food Code, dated 2022, reflected, .Food Storage.(B) . refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety