STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Le Reve Rehabilitation & Memory Care	3309 Dilido Road Dallas, TX 75228

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 0690

Level of Harm - Immediate jeopardy to resident health or safety

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 44405

Based on observations, interviews, and record review, the facility failed to ensure a resident with urinary incontinence, based on the resident's comprehensive assessment, who enters the facility with an indwelling catheter received appropriate treatment and services for 1 (Resident #1) of six residents reviewed for quality of care, in that:

LVN A, DON, and ADON failed to follow-up with physician after leaking was reported to the suprapubic catheter on 06/16/24 until 06/29/24 when surveyor intervened.

An Immediate Jeopardy (IJ) was identified on 06/30/24. The IJ template was provided to the facility on [DATE] at 4:30 PM. While the IJ was removed on 07/01/24, the facility remained out of compliance at a scope of isolated and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of the corrective systems.

This deficient practice placed residents at high risk of, or the likelihood of, serious injury or harm by not receiving treatment, developing complications such as injury to the urinary tract, and the development of sepsis.

Findings included:

Record review of Resident #1's Admission Record revealed a [AGE] year-old male, who admitted to the facility on [DATE] with the following diagnoses: Hemiplegia (refers to complete paralysis), affecting right dominant side; CKD, stage 2 (mild); retention of urine (a condition in which you are unable to empty all the urine from your bladder); and Down Syndrome.

Record review of Resident #1's Annual MDS assessment, dated 05/08/24, revealed a BIMS score of 12 which suggested Resident #1 had a moderate cognitive decline. Resident #1's functional status required one-person substantial/maximal assistance with ADLs. Resident #1 was always incontinent of bowel and had a suprapubic indwelling catheter (a flexible tube inserted into the bladder, through a cut in the abdomen, and remains in place for continuous drainage of urine into a drainage bag).

Resident #1's clinical physician orders reflected on the June 2024 Nurse Treatment Administration Record (nTAR) that each order was being performed as ordered:

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024
NAME OF PROVIDER OR SUPPLIER: Le Reve Rehabilitation & Memory Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 3309 Dilido Road Dallas, TX 75228	

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 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Order date - 05/05/23: Catheter care with soap and water every shift and as needed. Every shift. - Order date - 09/23/23: Suprapubic output every shift. - Order date - 03/04/24: Change Suprapubic catheter with 16F (size of tubing) catheter with 10 cc balloon every 4 weeks along side with bed side bag. Every night shift every 4 weeks on Sunday. - Order date - 06/10/24: Clean and change dressing at catheter insertion site in the morning [04:00 AM - 06:00 AM] - Order date - 06/16/24: Barrier cream to Suprapubic catheter PRN every 6 hours as needed for skin irritation of skin every 6 hours as needed for skin irritation. [Discontinued 06/16/24] The orders to flush urinary catheter with 30 cc normal saline as needed to maintain patency every 8 hours as needed to keep catheter patent [order date: 05/09/23 - discontinued] did not reflect on the June 2024 nTAR. Record review of the Order Summary Report reflected an order written, 05/09/24, to Flush urinary catheter with 30 cc normal saline as needed to maintain patency. Every 8 hours as needed to keep catheter patent. The order status was discontinued. Review of Resident #1's progress notes indicated: - Nurse's Note Effective Date: 06/16/24 at 6:32 PM, LVN A entered, SEE SBAR FOR SUPRAPUBIC CATH - Nurse's Note Effective Date: 06/29/24 at 4:25 PM, the DON entered, just spoke with [family member] . requesting resident go to [2 hospital choices] . EMT present. - Nurse's Note Effective Date: 06/29/24 at 11:33 PM, LVN D entered, [Resident #1] return back to facility . suprapubic [SPC] replaced, no leakage noted . new order for cefdinir 300 mg capsule (antibiotic) for infection. Record review of SBAR documentation reflected LVN A notified the PCP on 06/16/24 at 6:19 PM that Resident's #1 SPC was not draining, brief was soaked with urine, and [LVN A] recommendation was for Resident #1 to see Urologist. No new orders. A review of Resident #1's hospital medical records dated 06/29/24 reflected [Resident #1] arrived at theER on [DATE] at 5:10 PM. Review of the interpretation of the urinalysis collected 06/29/24 at 6:07 PM indicated Resident #1 had a urine infection. Resident #1's suprapubic catheter was changed in the ER and Resident #1 was discharged back to the facility with a prescription for an antibiotic to be administered for 7 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Le Reve Rehabilitation & Memory Care	3309 Dilido Road Dallas, TX 75228

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 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 06/29/24 at 10:10 AM, accompanied by CNA B, Resident #1 was observed in bed. [Catheter] Tubing dangled loosely from the right side of bed, attached to drainage bag. A cloudy yellow haze with white specks settled in the loop of the tubing and a scant amount of yellow cloudy urine was in the drainage bag. CNA B assisted by pulling back the covers to show the Suprapubic catheter (SPC) insert site at the lower abdomen above the pubic area. There was a 4x4 gauze placed over the site with one piece of paper tape horizontally placed across the top of the gauze, initialed and dated. The gauze flapped up and down as the covers were pulled back. There was leakage around the SPC insert site. CNA B detached the tape that secured the brief and pulled back between Resident #1's legs. The brief flopped down on the bed from the weight of the urine that filled the brief. The inner lining of the brief appeared squishy with yellow fluffy material that absorbed urine and had a strong odor. Resident #1 's pubic area was distended that indicated fullness from urine retention. There was a stat lock placed on Resident #1's right upper thigh to keep the catheter tubing from being pulled that appeared dirty and was pulled away from the skin. Resident #1 denied pain at the site but could not hold a meaningful interview due to his impaired cognition. During an interview on 06/29/24 at 10:38 AM, CNA B said she was familiar with Resident #1's care needs. CNA B said that she reported to LVN A the past 2 weekends (June 15 and 16; June 22 and 23) that Resident #1's brief was filled with urine and none in the drainage bag. CNA B said that LVN A acknowledged and informed that she notified the PCP. CNA B said that she notified LVN A because a urine filled brief was not normally seen with residents who had [urine] catheters. CNA B said that it was her responsibility to prevent skin breakdown by making sure Resident #1 was maintained clean and dry. During an interview on 06/29/24 at 3:43 PM, the DON said that she was familiar with Resident #1 and indicated Resident #1 recently had his [SPC] catheter replaced on or about May 26, 2024, when Resident #1 was sent to the hospital due to leaking around the insert site. The DON was informed by the surveyor the observation findings (06/29/24 at 10:10 AM). The DON said she had not been informed by LVN A or reviewed in the 24-hour reports about any change of condition since then related to Resident #1's urinary catheter. The DON said that she expected nurses to notify the MD, ADON, DON and NFA of any resident change in condition, the cause of decline and how the cause was determined. The DON said that she would expect the nurse to report to the MD, signs and symptoms, interventions, effectiveness, and to document communication with the MD. The DON said that she would expect the nurse to follow up with the MD if she did not get a reply within thirty minutes and notify the oncoming nurse to follow up as needed. The DON said that the nurse should maintain awareness of the resident's condition to be able to recognize changes and be knowledgeable of nursing interventions. During an outbound call on 06/30/24 at 4:30 PM, the FMD indicated vaguely recalled being notified about Resident #1's SPC leaking. Notifications were sent via a group text phone app. The FMD recalled an order was given to replace the SPC with a larger tubing and the resident ended up being sent out to the hospital (this incident occurred the end of May 2024 and was not relevant to the incident that occurred on 06/16/24). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024
NAME OF PROVIDER OR SUPPLIER Le Reve Rehabilitation & Memory Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3309 Dilido Road Dallas, TX 75228	

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 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview and record review on 07/01/24 at 12:03 PM, the ADON said she was familiar with Resident #1. The ADON described Resident #1's care needs as one person assist with ADLs and had a SPC. The ADON said that the nurses performed catheter care per shift to assess for any issues, such as leaking or drainage around insert site, cracks in the tubing, urine output and characteristics. The ADON indicated that the CNA also checked the catheter during incontinent care for any concerns that should be reported to the nurse. The ADON said that it was the nurse's responsibility to ensure catheter care was provided during their shift and as needed. The ADON said that the assigned nurse must ensure proper catheter care and the catheter must remain patent. Patency was maintained by flushing the catheter with 30 cc normal saline. The ADON indicated that catheter flushing was part of urinary catheter care batch orders. The ADON described a change in condition as anything outside of what was normal for the resident, not eating or sleeping more than usual. The ADON said that the nurse should assess the resident to determine the cause of change in condition, immediately notify the MD, then document findings. The ADON said that the SNF used a secured messaging app to notify the MD about resident clinical status and send pictures if needed. The ADON said that she, the DON, and NFA were included on MD notifications via the messaging app. The ADON reviewed the messaging app and saw that there was a message on 06/16/24 about Resident #1's SPC leaking and urine-soaked brief, without a reply from the MD. The ADON said that her expectation was that every nurse be responsible for the assignment given and for nurses to inform leadership when they were busy and needed assistance. An outbound phone call to LVN A on 06/29/24 at 12:40 PM, 06/30/24 at 1:10 PM and 07/01/24 at 6:15 PM were unanswered. LVN A did not return the phone calls. An outbound phone call to speak with Resident #1's RP on 06/29/24 at 12:54 PM was not answered. Record review of the facility's Suprapubic Catheter Care policy, revised October 2010, reflected the purpose of the procedure was to prevent skin irritation around the stoma site and to prevent infection of the resident's urinary tract. General Guidelines reflected: Observe the resident's urine level for noticeable increases or decreases. Should the resident indicate that his or her bladder is full or needs to void, report immediately to your supervisor. Observe the resident for signs and symptoms of urinary tract infection and urinary retention. Report findings to your supervisor. Notify the physician of any abnormalities in the skin assessment or the character of urine. Report other information in accordance with facility policy and professional standards of practice. Record review of the facility's Change in a Resident's Condition or Status policy, revised May 2017, reflected the purpose to ensure resident's family and physician are notified of changes that fall under: - an accident resulting in injury that has the potential for needed physician interventions (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024
NAME OF PROVIDER OR SUPPLIER Le Reve Rehabilitation & Memory Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3309 Dilido Road Dallas, TX 75228	

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 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- a significant change (example given: Abnormal lab results) - a need to significantly alter treatment - transfer of the resident from the facility Record review of the facility's Acute Condition Changes - Clinical Protocol policy, reviewed December 2022, reflected assessment and recognition, cause identification, treatment/management, monitoring and follow-up: 1. During the initial assessment, the physician will help identify individuals with a significant risk for having acute changes of condition during their stay; for example, and individual with an indwelling urinary catheter who has had recurrent symptomatic UTIs, someone with unstable VS, or recurrent pneumonia. 2. In addition, the nurse shall assess and document/report the following baseline information: VS; neurological status; current level of pain, and any recent changes in pain level; LOC . 3. Direct care staff, including nursing assistants will be trained in recognizing subtle but significant changes in the resident (for example, a decrease in food intake, increased agitation, changes in skin color or condition) and how to communicate these changes to the nurse. 6. Before contacting a physician about someone with an acute change of condition, the nursing staff will make detailed observations and collect pertinent information to report to the Physician; for example, history of present illness and previous and recent test results for comparison. a. Phone calls to attending or on-call physicians should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident's current symptoms and status. b. Nurses are encouraged to use the SBAR Communication Form and Progress note as a tool to help gather and organize information before notifying the Physician. the purpose to ensure resident's family and physician are notified of changes that fall under: - an accident resulting in injury that has the potential for needed physician interventions - a significant change (example given: Abnormal lab results) - a need to significantly alter treatment - transfer of the resident from the facility The NFA was notified of an Immediate Jeopardy (IJ) on 06/30/24 at 4:30 PM, due to the above failures and the IJ template was provided. The facility's Plan of Removal (POR) was accepted on 07/01/24 at 1:54 PM and included: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024
NAME OF PROVIDER OR SUPPLIER: Le Reve Rehabilitation & Memory Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 3309 Dilido Road Dallas, TX 75228	

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 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Per the information provided in the IJ template given on 6/30/24, the facility failed to ensure that all nursing staff had training on foley catheter care and prevention of UTI/CAUTI. Facility failed to ensure a resident with urinary incontinence based on the resident's comprehensive assessment who entered the facility with an indwelling catheter received appropriate treatment and services to prevent UTI. 1. The medical director was notified of IJ on 6/30/24 at 04:35p.m. 2. Review completed by DON of all residents with catheters in facility to assure appropriate monitoring and treatment orders are in place. 3. Chart audits initiated by the DON and ADON on 6/29/24 for all residents with catheters to ensure documentation was noted in the chart. 4. DON, ADON, and clinical leadership-initiated education with nurses and CNAs on monitoring catheters, catheter care, and UTI/CAUTI prevention. 5. Inservice training and education will include determining significant changes, reporting s/s of change in condition, and communicating with department heads and MD/NP changes in condition. 6. Clinical corporate leadership provided education to DON on 6/30/24. 7. All licensed nurses will start competency skills checkoffs on catheter care starting on 6/30/24. 8. All CNAs will complete competency on catheter care initiated on 6/30/24. 9. This training and competencies will be completed in-person with all staff prior to the start of their next shift. Staff will not be allowed to work until they have completed the training and competency skills checkoffs. This training will be included upon new hire orientation and for PRN staff. 10. A QAPI meeting will be held 7/1/24 regarding the items in the IJ template that will include the following attendees: Medical Director, DON, ADON, Executive Director, Clinical Resource, and additional IDT members. The QAPI meeting will include the plan of removal items and interventions. 11. All residents with catheters will be reviewed during the weekly clinical meetings and the medical director will be consulted for any recommendations or suggestions as necessary. Meeting attendees will include the DON, ADON, Rehab Director, MDS 12. Coordinator. The DON and Executive Director will be responsible for ensuring this meeting is held weekly and all residents with catheters are reviewed. 13. Summary of IJ and corrective action to be reviewed by QAPI committee weekly x4 weeks or until substantial compliance established and continue monthly for 90 days to ensure ongoing compliance. On 07/01/24 the surveyor began monitoring if the facility implemented their plan or removal sufficiently to remove the IJ by: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024
NAME OF PROVIDER OR SUPPLIER Le Reve Rehabilitation & Memory Care		STREET ADDRESS, CITY, STATE, ZIP CODE 3309 Dilido Road Dallas, TX 75228	

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 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of QAPI meeting minutes dated 07/01/24 revealed the QAPI team met to discuss the facility's failure to ensure nursing staff had received training on catheter care and prevention of UTI/CAUTI and steps the facility were taking to address the concern. During an interview and record review on 07/01/24 at 2:49 PM, the DON indicated that she conducted surveillance rounds to visualize each resident's (six residents) urinary catheter site for s/s of infection and patency. The DON indicated that she performed a chart audit on each of the six residents with a urinary catheter to assure appropriate monitoring and treatment orders were in place. Record review of order summaries for the six residents revealed treatment orders were entered and nTAR reflected orders were performed. Interviews conducted with nurses and CNAs scheduled on the 6A - 2P shift [RN F, CNA L, CNA J, MA M, LVN G, CNA I, and CNA N], on the 2P - 10P shift [LVN C, CNA O, CNA P, and CNA Q], and 10P - 6A shift [RN R] indicated they participated in an in-service training about recognizing change in condition, s/sx of UTIs, physician notification, and ANE. The topic of discussion included physician notification, documentation, and follow up orders. Each nurse stated in their own words the procedure was to notify physicians immediately about resident change in condition, verbalized steps taken to notify physician, entering and implementing new orders. Record review of in-services conducted by the DON and ADON dated 06/30/24 - 07/01/24 titled Flushing Supra-pubic Catheter (and irrigation) and Catheter Care - Infection Control, including pre-/post-test were on-going to achieve 100% nursing dept participation. On 06/30/24, an Immediate Jeopardy was identified. The NFA was notified and provided an IJ template on 06/30/24 at 4:30 PM. While the IJ was lowered on 07/01/24, the facility remained out of compliance at a scope of isolated and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Le Reve Rehabilitation & Memory Care	3309 Dilido Road Dallas, TX 75228

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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44405 Based on observations, interviews, and record review, the facility failed to promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results according to facility policies and procedures for notification and the medical orders for 1 (Resident #1) of six residents reviewed for laboratory services, in that: The facility failed to notify the physician of the urinalysis (UA) results that were reported on 06/28/24. The UA results suggested Resident #1 may have had an UTI. This deficient practice placed residents at high risk of, or the likelihood of, delay in care or treatment. Findings included: Record review of Resident #1's Admission Record revealed a [AGE] year-old male, who admitted to the facility on [DATE] with the following diagnoses: Hemiplegia (refers to complete paralysis), affecting right dominant side; CKD, stage 2 (mild); retention of urine (a condition in which you are unable to empty all the urine from your bladder); and Down Syndrome. Record review of Resident #1's Annual MDS assessment, dated 05/08/24, revealed a BIMS score of 12 which suggested Resident #1 had a moderate cognitive decline. Resident #1's functional status required one-person substantial/maximal assistance with ADLs. Resident #1 was always incontinent of bowel and had a suprapubic indwelling catheter (a flexible tube inserted into the bladder, through a cut in the abdomen, and remains in place for continuous drainage of urine into a drainage bag). Resident #1's clinical physician orders reflected on the June 2024 Nurse Treatment Administration Record (nTAR): - Order date - 06/24/2024: UA with C&S A record review of Resident #1's urinalysis (UA) collected on 06/25/24 and resulted on 06/28/24 at 11:51 AM indicated the review status was To Be Reviewed. The results reflected abnormal readings outside the reference range that suggested a urinary tract infection (UTI). The physician was not notified of the results. Review of Resident #1's progress notes indicated: - Nurse's Note Effective Date: 06/24/24 at 9:56 PM, LVN C entered, . collect UA/C&S tonight. - Nurse's Note Effective Date: 06/29/24 at 4:25 PM, the DON entered, just spoke with [family member] . requesting resident go to [2 hospital choices] . EMT present. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Le Reve Rehabilitation & Memory Care	3309 Dilido Road Dallas, TX 75228

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 0773

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

- Nurse's Note Effective Date: 06/29/24 at 11:33 PM, LVN D entered, [Resident #1] return back to facility . suprapub [SPC] replaced, no leakage noted . new order for cefdinir 300 mg capsule (antibiotic) for infection.

On 06/29/24 Resident #1 was sent to the ER after surveyor intervention. Resident #1 was diagnosed , treated for a urinary tract infection (UTI), and the SPC replaced.

A review of Resident #1's hospital medical records dated 06/29/24 reflected [Resident #1] arrived at theER on [DATE] at 5:10 PM. Review of the interpretation of the urinalysis collected 06/29/24 at 6:07 PM indicated Resident #1 had a urine infection. Resident #1's suprapubic catheter was changed in the ER and was discharged back to the facility with a prescription for an antibiotic to be administered for 7 days.

During an observation and interview on 06/29/24 at 10:10 AM, accompanied by CNA B, Resident #1 observed in bed. [Catheter] Tubing dangled loosely from the right side of bed, attached to drainage bag. A cloudy yellow haze with white specks settled in the loop of the tubing and a scant amount of yellow cloudy urine was in the drainage bag. CNA B assisted by pulling back the covers to show the Suprapubic catheter (SPC) insert site at the lower abdomen above the pubic area. There was a 4x4 gauze placed over the site with one piece of paper tape horizontally placed across the top of the gauze, initialed and dated. The gauze flapped up and down as the covers were pulled back. There was leakage around the SPC insert site. CNA B detached the tape that secured the brief and pulled back between Resident #1's legs. The brief flopped down on the bed from the weight of the urine that filled the brief. The inner lining of the brief appeared squishy with yellow fluffy material that absorbed urine and had a strong odor. Resident #1 's pubic area was distended that indicated fullness from urine retention. There was a stat lock placed on Resident #1's right upper thigh to keep the catheter tubing from being pulled that appeared dirty and was pulled away from the skin. Resident #1 denied pain at the site but could not hold a meaningful interview due to his impaired cognition.

During an interview on 06/29/24 at 3:43 PM, the DON said that she was familiar with Resident #1 and indicated Resident #1 recently had his [SPC] catheter replaced on or about May 26, 2024, when Resident #1 was sent to the hospital due to leaking around the insert site. The DON said she had not been informed by LVN A or reviewed in the 24-hour reports about any change of condition since then related to Resident #1's urinary catheter. The DON said that she expected nurses to notify the MD, ADON, DON and NFA of any resident change in condition, the cause of decline and how the cause was determined. The DON said that she would expect the nurse to report to the MD signs and symptoms, interventions, effectiveness, and to document communication with the MD. The DON said that she would expect the nurse to follow up with the MD if she did not get a reply within thirty minutes and notify the oncoming nurse to follow up as needed. The DON said that the nurse should maintain awareness of the resident condition to be able to recognize change and be knowledgeable of nursing interventions.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Le Reve Rehabilitation & Memory Care	3309 Dilido Road Dallas, TX 75228

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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/01/24 at 12:03 PM, the ADON said she was familiar with Resident #1. The ADON described Resident #1's care needs as one person assist with ADLs and had a SPC. The ADON said that the nurses performed catheter care per shift to assess for any issues, such as leaking or drainage around insert site, cracks in the tubing, urine output and characteristics. The ADON indicated that the CNA also checked the catheter during incontinent care for any concerns that should be reported to the nurse. The ADON said that it is the nurse responsibility to ensure catheter care was provided during their shift and as needed. The ADON said that early s/sx of a urinary tract infection included changes in urine characteristics - color, output, smell, abnormal lab values, change in behavior, or fever. The ADON said that the nurse should assess the resident to determine cause of change in condition, immediately notify the MD, then document findings. The ADON said that the SNF used a secured messaging app to notify the MD about resident clinical status and send pictures if needed. The ADON said that she, the DON, and NFA were included on MD notifications via the messaging app. There was no message on 06/28/24 to notify the MD about Resident #1's lab results. The ADON said that her expectation is that every nurse be responsible for the assignment given and for nurses to inform leadership when they are busy and need assistance. Record review of an in-service conducted by the DON dated 06/30/24 titled Labs/Reporting/MD Notification was on-going to achieve 100% nursing dept participation. The in-service topic of discussion revealed the steps of procedure, frequency of checking labs, physician notification, documentation, and follow through. The sign in sheet reflected the following participants: RN U, LVN E, RN K, LVN D, LVN G, and RN F. A review of the Lab and Diagnostic Test Results - Clinical Protocol reviewed December 2022, indicated: - The physician will identify and order diagnostic and lab testing; staff will process test requisition and arrange for test; the laboratory, diagnostic provider will report results to facility - A nurse will review all results and report the finds to the physician/designee - A physician can be notified by phone, fax, voicemail, e-mail, mail, pager, or a telephone message to another person acting as the physician's agent (for example, office staff) - A physician will respond within an appropriate time frame, based on the request from the nursing staff and the clinical significance of the information. This response maybe by calling the facility or writing new orders.