

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 12/09/2024
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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50444</p> <p>Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (Resident #1) of three resident reviewed for infection control.</p> <p>The facility failed to ensure on 12/09/24 LVN A avoided taking a bottle of wound cleanser and a tube of medicated cream into the resident's room, and then returning the containers to the treatment cart, which contained treatment supplies for other residents.</p> <p>This failure could place residents at risk of cross-contamination and development of infections.</p> <p>Findings included:</p> <p>Review of Resident #1's Face Sheet, dated 12/09/2024, reflected resident was an [AGE] year-old male admitted on [DATE]. Resident #1 had a diagnosis of left ankle pressure ulcer.</p> <p>Review of Resident #1's Quarterly MDS (tool used to measure health status) Assessment, dated 11/27/2024, reflected moderate cognitive impairment with a BIMS score of 11. Section M reflected a pressure reducing device for the bed and chair.</p> <p>Review of Resident #1's [NAME] Wound Physician's Order, dated 12/05/2024, reflected NON - PRESSURE WOUND OF THE LEFT, LATERAL ANKLE FULL THICKNESS Primary Dressing(s) Santyl (medicated skin cream) apply once daily for 24 days; Xeroform (non-adherent dressing with antimicrobial) gauze apply once daily for 24 days Secondary Dressing(s) Gauze Island w/ bdr apply once daily for 24 days.</p> <p>Review of Resident #1's Comprehensive Care Plan, dated 12/06/2024, reflected will have intact skin, free of redness, blisters, or discoloration by/through review and one intervention listed was to Follow facility policies/protocols for the prevention/treatment of skin breakdown.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 12/09/24 at 03:05 PM revealed LVN A washed his hands and prepared the items needed for Resident #1's wound care. The medicated cream was stored in a small plastic bowl in the top drawer of the treatment cart. No other items were in the bowl. A spray bottle containing wound cleanser was taken from the top of the medication cart. Other wound care supplies were taken from another drawer of the treatment cart. LVN A did not sanitize the bottle of wound cleanser, the bowl containing the medicated cream, or the tube of medicated cream prior to taking these items into the resident's room. LVN A placed a barrier pad on one side of the resident's bedside table and placed the wound care items on the pad. LVN A did not sanitize the bedside table prior to placing the barrier pad on it. The small bowl containing the tube of medicated cream was placed on the other side of the bedside table where the resident had some personal items. LVN A washed his hands and put on clean gloves. He opened the dressing packages and applied the medicated cream to the xeroform gauze. LVN A adjusted the pillow under the resident's left leg to access the left ankle. LVN A peeled off the old dressing from the resident's left ankle and discarded it. He removed his gloves and washed his hands in the resident's room. He applied clean gloves, sprayed wound cleanser on the wound, and used gauze pads to clean the wound. LVN A washed his hands and put on clean gloves. He applied the xeroform gauze, then the secondary dressing to cover the wound. LVN A washed his hands. LVN A removed the bottle of wound cleanser and medicated cream from the resident's room. He placed the wound cleanser and small bowl containing the medicated cream on top of the treatment cart. He used hand sanitizer to clean his hands. LVN A unlocked the treatment cart and returned small bowl containing medicated cream to the top drawer of the treatment cart. LVN A did not sanitize the bottle of wound cleanser, the bowl containing the medicated cream, or the tube of medicated cream. LVN A stated he had been a nurse for many years and had experience providing wound care. LVN A stated at this facility the night shift nurse performed the wound care, so he did not do wound care. LVN A stated he should have sanitized the items before and after use in the resident's room, or put the medicated cream and wound cleanser in clean medication cups prior to going in the resident's room instead of taking the containers in. He stated this could cause cross contamination since they were taken into the resident's room and returned to the treatment cart.</p> <p>In an interview 12/09/24 at 03:20 PM, the DON stated to prevent cross contamination and for infection control purposes, the spray bottle of wound cleanser and tube of medicated cream should not have been taken into the resident's room and returned to the treatment cart. The DON stated there are small plastic medication cups available for the nurses to place creams or wound cleanser in to take into a resident's room. The DON stated she would in-service the nursing staff regarding this.</p> <p>Review of facility's policy Infection Control Policies and Practices, Revised October 2013, reflected maintain . sanitary environment . to help prevent and manage transmission of diseases and infections.</p>		