STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675305	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Valley Healthcare and Rehabilitation Cent	1525 Pleasant Valley Rd Garland, TX 75040

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observation, interview, and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for one (Resident #16) of 8 residents reviewed for Resident Rights. The facility failed to ensure Resident #16 was accommodated with a call light to meet her needs in order to call for assistance when she needed it. This failure could place residents at risk of not being able to call for staff assistance, which could cause delays with getting ADL care, pain management and other healthcare needs leading to health decline and decreased psycho-social well-being. Findings included: Record review of Resident #16's Admission MDS assessment dated [DATE] revealed a [AGE] year-old female who admitted [DATE] with a BIMS Score of 10 (Moderately impaired). She was impaired on both sides, upper and lower and used a wheelchair. She required substantial/maximal assistance with toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. And she required substantial/maximal assistance transferring sit to lying, chair to bed, toilet transfer and had a progressive neurological condition. She had active diagnoses of Deep vein thrombosis (blood clot), hypertension (high blood pressure), wound infection, diabetes mellitus, hyperlipidemia (high fat particles in blood), CVA (stroke), Non-Alzheimer's Dementia, anxiety and depression. Record review of Resident #16's Care Plan undated revealed, Date initiated: 01/10/24 - ADL Self-care Performance deficit related to weakness - interventions: Date initiated: 03/13/24 flat call light within reach. Date initiated 01/18/24 - Has limited physical mobility related to weakness - Interventions: Date initiated 01/18/24 Provide supportive care, assistance with mobility as needed. Document assistance as needed. Date initiated: 01/10/24 - has bowel/bladder incontinence related to cognition, confusion, and weakness - Interventions: incontinent- Check as required for incontinence. Date initiated 01/10/24 - At risk for falls related to poor balance - Interventions: Be sure the call light is within reach and encourage to use it to call for assistance as needed. Date initiated: 01/10/23 - Has potential acute/chronic pain related to debility, Neuropathy, muscle spasms - Interventions: Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM, withdrawal, or resistance to care. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and Observation on 03/12/24 at 11:45 am, Resident #16 was sitting up in her wheelchair and her call light was lying next to her, but she was unable to move her fingers to grab and press the button, she stated she could not use her call light button any longer. She stated when she first admitted she used to be able to do more for herself but now she needed more staff assistance. She stated it had been hard for her to press her call light button for about a month. Interview and observation on 03/13/24 at 3:24 pm, Resident #16 lying in bed, call light within reach, she said she was still not able to press the call light button because her fingers were too stiff. She stated she had to struggle to put the call light up to her mouth to turn it on but sometimes the call light did not appear to work right. She stated she would really like to get a soft touch call light. Interview on 03/13/24 at 2:44 pm, DOR stated Resident #16 had a stroke and was currently getting OT, ST, and PT to improve her ADL and ROM due to her stroke. He stated she had limited movement of her hands and range of motion on her weak side. Interview on 03/13/24 at 3:00 pm, OT B stated Resident #16 was evaluated yesterday 03/12/24 for a complaint of right-hand pain and her swollen left hand. He stated he spoke to Resident #16's nurse about pain management and the swelling her hand but not about the need for a soft touch call light. He stated not noticing she could not press her call light but agreed Resident #16 could benefit from a soft touch call light because of the stroke she had affecting her right hand and her swollen left hand. He stated with the soft touch call light Resident #16 could easily use her hand or elbow to get service. He stated if a resident was not able to effectively use their call light, they would not be able to call for help. Interview and observation on 03/13/24 at 3:34 pm, CNA C stated he cared for Resident #16 often and did not know she could not press her call light. He stated he was going to check with her nurse about getting a soft touch call light. He stated a lot of stuff could happen to a resident if they were not able to press their call lights, they could fall, and incidents could happen to them. Observation on 03/13/24 at 4:00 pm, LVN E was educating Resident #16 about how to use the soft touch call light and the resident demonstrated understand by pressing it with the back of her hand and the call light started ringing. Interview on 03/13/24 at 4:05 pm, RN D stated she was informed of Resident #16's need for a soft touch call light today (03/13/24) and added the soft touch call light was better for Resident #16 to use because she did not have enough strength to press the push button call light. Interview on 03/13/24 at 4:15 pm, the DON stated she was unaware Resident #16 was not able to press her call light button. She stated but now that they knew, they replaced it today (03/13/24) with a soft touch call light. She stated not being sure why Resident #16 had not already had a soft touch call light and planned to talk to the staff and the resident about the issue. She stated she was going to talk to the staff about the breakdown in communication and reporting it accordingly to the nurse. She stated there could be a delay and residents getting assistance if they were not able to press their call lights effectively. She stated she was responsible for ensuring the staff understood the processes when a resident was not able to use their call lights effectively. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/14/24 at 1:14 pm, OM stated Resident #16's hands were starting to regress, and she was not able to use them. He stated not being aware of her need for a soft touch call light, until just recently. He stated Resident #16 had a soft touch call light now. He stated the DON was responsible for ensuring the nursing staff assessed the residents needs for more appropriate call light. He stated his expectations for call light assessment was for the staff to notify the DON, their doctor and family immediately to get them assessed for a more appropriate call light. Request of the facility's Resident Rights policy was requested on 03/14/24 but the OM did not provide it prior to exit. Record review of the Facility's Call light policy dated 05/2023 revealed, Policy: It is the policy of this facility to provide the resident a means of communication with nursing staff .

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 47855 Based on observation, interview, and record review, the facility failed to provide a private meeting space for the residents' monthly council meetings for 13 of 13 confidential residents reviewed for resident council. The facility failed to provide a private space for resident council meetings. This failure could place residents, who attended resident council meetings, at risk of not being able to voice concerns due to a lack of privacy. Findings included: Observation and interview on 03/13/24 beginning at 10:00 AM, during a confidential resident group meeting with 13 residents, revealed the meeting was held in the dining room. There were no doors or solid walls to separate the dining hall from the open activity/tv area. There were no signs posted to indicate that a confidential meeting was being held; however, multiple staff walked through the space to get to the kitchen and employee breakroom. During the confidential group meeting, 3 of the 13 residents revealed the meeting was held each month in the dining room or the library. 7-8 of the residents stated it was their first meeting. 2-3 others had fallen asleep. They all agreed that there was no privacy and staff could overhear them. The residents didn't know they had the right to private meeting. The former and current resident council presidents were both unaware of the right to have a private meeting without staff or other interruption. Interview on 03/13/24 at 2:35 PM with the Case Manager, revealed the activity director resigned last week due to family issues. She was responsible for the setup and planning of the meeting with the residents. She stated that she is helping until a new activity director can be put in place. She stated that she is helping, so she wasn't aware of the requirements other than it had to be monthly and for the residents. She stated that she understood the need for privacy and that it could make a resident feel awkward about being out in the open. She stated that she would also look for a place that offers privacy and is big enough for everyone to attend and offer more privacy and no interruptions. She offered the therapy gym as a possible location and then considered the activity area at the end of the hall. She expects them to hire a new activity director sometime soon and the responsibility will go to that person. Interview on 03/14/24 at 3:45 PM with the Operations Manager revealed the resident council meetings were always held in the dining room. He stated they have always met there. He stated that he understands the need for privacy but didn't think that was a problem. He stated that he would move the meeting to a different area. He first considered the therapy gym, but then thought the activity area was a better place to have the meeting as no one really goes to that area. He stated there have been no complaints to him about privacy, many of the residents in the council are outspoken and have no problem saying what they need to say. The Operations Manager stated his expectation was for the residents to have the privacy they deserve so they can voice their concerns openly. Record review of the resident council minutes for December, January and February, revealed no requests for a more private area. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Resident Council policy, 07/2022 revision, revealed in part the following: Page 2 Section labeled Meeting, 1. Meetings shall be held monthly in the dining room or library to be accessible to all residents unless otherwise designated by the President of presiding officer. Lists the meeting area as the dining room or library, makes no mention of privacy or required postings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42859 Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident on one of three medication carts (hall 400 nurses' cart) and 2 of 2 Residents (# 16 and #37) reviewed for pharmacy services. 1.The facility failed to ensure the hall 400 nurses medication cart contained accurate narcotic record for Residents #37 and #16. 2. The facility failed to ensure a bottle of Benadryl tablets that were expired were removed from the 400 Hall medication cart. This failure could place residents at risk for drug diversion, delay in medication administration and at risk of receiving medications that were ineffective. Findings included: 1. Review of Resident #16's face sheet, dated 03/14/24, reflected the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE]. Resident #16's diagnoses included pressure ulcer of sacral region stage 3 (.skin injuries that occur in the sacral region of the body, near the lower back and spine that involves the full thickness of the skin and may extend into the subcutaneous tissue layer). Review of Resident #16 MDS revealed a BIMS score of 04 revealing she had severe cognitive impairment. Review of Resident#16 care plan dated 01/10/24 revealed potential acute/chronic pain rule out. Debility. The goals Will voice a level of comfort of through the review date. Interventions are: Observe and report changes in usual routine, sleep patterns, decrease in functional. Abilities, decrease ROM, withdrawal, or resistance to care. Pain assessment every shift. Review of Resident#16 physician's orders dated 12/21/23 revealed Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 06 hours as needed for pain. Review of the progress notes dated 3/13/24 at 01:59AM revealed, Hydrocodone-Acetaminophen Oral Tablet 5-325 MG. Give 1 tablet by mouth every 06 hours as needed for pain. Resident medicated for complain of pain 7/10 on her right hand. Per as needed orders. 2.Review of Resident #37's face sheet, dated 03/14/24, reflected the resident was a [AGE] year-old female who was initially admitted to the facility on [DATE]. Resident #37's diagnoses included primary osteoarthritis (disease that worsens over time, often resulting in chronic pain. Joint pain and stiffness). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #37 MDS revealed a BIMS score of 00 revealing she had severe cognitive impairment. Review of Resident#37 care plan dated 08/27/23 revealed Has acute/chronic pain rule out Arthritis. Debility. The goals Will voice a level of comfort of through the review date. Interventions are: Anticipate need for pain relief and respond immediately to any complaint of pain. Follow pain scale to medicate as ordered. Pain assessment every shift. Review of Residnt#37 physician's orders dated 07/01/22 revealed Tramadol HCl Tablet 50mg.Give 1 tablet by mouth every 6 hours as needed. Observation on 03/13/24 at 10:26 AM, of the hall 400 nurse's cart and the narcotic administration record, with LVN E, revealed the following information: Resident #37's narcotic administration record sheet for Tramadol 50mgs was last signed off on 03/13/24 for one-tablet dose given at 01:59 AM, for a total of 7 pills remaining while the blister pack count was 8 pills signed by RN G. Resident #16's narcotic administration record sheet for Norco 5/325mgs was last signed off on 03/12/24 for one-tablet dose given at 16:00 PM, for a total of 55 pills remaining while the blister pack count was 54 pills. Did not have the name of the nurse that signed off. There was also a bottle of Benadryl with an expiry date of 02/24. Interview with LVN E on 03/13/24 at 10:48 AM, revealed it was her first time working on 400 hall. She stated she had not administered the Tramadol 50mgs and Norco 5/325mgs to resident's #37 and #16 during her shift . She stated she counted with outgoing nurse, and she had not realized the count were not correct. She stated when the narcotic log shows more or less medications it meant ether the resident received the medication and the nurse forgot to log off or the nurse were signing, they gave when they had not given . She stated the failure could lead to resident being overdosed because it is hard to tell when the medication was administered last, resident missing a dose, diversional and resident being in uncontrolled pians that would affect participating on her daily activities . She stated it was nurses' responsibility to check the carts for expired medications. She stated she checked the cart, in the morning and she did not see a Benadryl bottle. She stated failure to remove the expired medications on the cart, if administered it will not be effective. LVN E stated the procedure when taking over at the change of shift was to count physical medications on the blister pack and compare with narcotic administration record. Interview with Resident #16 on 03/13/24 at 11:32AM revealed she was administered a pain pill by the night nurse. Interview with Resident #37 on 03/13/24 at 11:38AM revealed she was not administered a pain pill and she could not remember the last time she was administered one. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the ADON on 03/13/24 at 12:51PM revealed it was all nurse's responsibility to follow the five rights of administering medications that are not limited to ensuring the narcotic logs are balancing with the count. He stated he expected the nurse to ensure the counting during shift change were correct and report any discrepancies to the ADON and the DON. He stated it was also the nurse's responsibility to ensure they check their carts for expired medications. The ADON stated it was his responsibility to monitor the carts, but he is new to the facility, he had not gone through the carts. The ADON stated failure to ensure the correct count could lead to medication error and diversion. He stated expired medication if administered they would not be effective. Interview with RN G on 3/14/24 at 09:28AM revealed she was the night shift nurse on 3/12/24. She stated she was the one that administered Norco 5/325 mgs 1 tablet at 01:59 AM to Resident#16 and logged of on Resident #37 narcotic log. She stated she thought she signed-out on the narcotic count sheet for Residnet#16. She stated failure to log on the right resident narcotic log would cause the narcotic count to show less on the next count and it could lead to a narcotics diversion and uncontrolled pains . She stated she had done in-services on medication administration. Interview on 03/14/24 at 12:34 P M, the DON revealed her expectation was for staff administering narcotic medications to document the medications when they were given to the resident on the medication administration record and to sign on the narcotic log to prevent discrepancies and to have proof the medications were administered. The DON stated she expect the handing over to be done by 2 nurses and to report any discrepancy to her. She stated nurses are responsible of ensuring there no expired medications on their carts .The DON stated risk of not logging after administering the medication was that the resident can be administered an overdose or miss the dose. She also stated failure to remove the expired medications from the cart if administered they will not be effective. She stated the nursing management were responsible of checking the carts after the nurses. She stated she had done training on narcotic administration and logging off and no trainings were provided that were done prior to surveyor interventions. Review of the facility current Administration of Drugs policy, dated 2007, reflected the following: 10. The nurse administering the medications must initial the resident's MAR, on the appropriate line and date for that specific day. Review of the facility current Controlled Medications - Storage and Reconciliation policy, dated 2023, reflected the following: 6. When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: o Date and time of administration. o Amount administered. o Signature of the nurse administering the dose, completed after the medication is actually administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. A reconciliation or physical inventory of all controlled medications is conducted by two licensed nurses and is documented on an audit record at each shift change. Alternatively, the shift change audit may.be recorded on the accountability record if there is a designated column for the audit."

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 32581 Based on interview and record review the facility failed to have a governing body appointing the administrator who was licensed by the state, where licensing was required, responsible for the management of the facility and reported to and accountable to the governing body for one (facility) of one reviewed for Administrator. The facility failed to appoint an Administrator who was responsible for the management and operations of the facility. Some of the facility staff were not aware of who the facility Administrator was, and the identified Administrator was not actively involved in the day-to-day operations and management of the facility. Subsequently, the OM delayed reporting alleged Abuse/neglect to the identified Administrator and HHSC within the required timeframes. This failure could place residents at risk of inadequate response times when responding to abuse, neglect, and exploitation allegations, which could cause continued ANE, resulting in injury and decreased psycho-social well-being. Findings included: Interview on 03/12/24 at 9:30 am, ADON stated he was not sure who the facility's Administrator was but said he would have to go check. Interview by phone on 03/12/24 at 2:19 PM, Administrator A stated he Interworked (worked together) with this facility for the past six weeks and at the facility three times since then. He stated he mostly interacted with the OM about what was occurring at the facility until OM's Administrator's license transferred from another state because he currently did not have a Texas Administrator's license. He stated he did not attend the standup meetings in person or by phone but spoke to OM multiple times a week. He stated the OM managed the facility including the emergency preparedness plan and there were no other staff who contacted him about anything including Abuse, Neglect, Exploitation. He stated OM told him about Resident #5's Abuse allegation and was not sure when he was notified but knew it was reported to HHSC and investigated. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 3/14/24 at 10:34 am, the OM stated he moved here from another state and was in the process of getting his Texas Administrator's license. He stated he needed a document notarized for his license to be transferred to the state of Texas. He stated he spoke to Administrator A daily about things going on at the facility. He stated today (03/14/24) he was clarifying with the staff who was the administrator because some of the staff had it mixed up and thought he was the Administrator. He stated he told the staff to continue to report ANE allegations and any other concerns to him. He stated Administrator A was physically at the facility three times since January 2024. He stated the role of the Administrator was to oversee the facility's day to day operation and all that entailed it, according to the state and federal government. He stated Administrator A did not work at the facility 40 hours every week and was just helping him until he received his license. He stated he would have to double check the policy on if they had to have a fulltime administrator at the facility. He stated he was the ANE coordinator designated by the administrator and the staff knew to contact him directly and Administrator A was secondary if he was not reachable. Interview on 03/14/24 at 12:50 pm, the DON stated she saw Administrator A maybe five times at this facility and was not sure how long he had been this facility's Administrator. She stated Administrator A was available by phone 24/7 and his phone number was posted for all staff to call him directly. She stated not being sure how long Administrator A was the administrator at this facility. She stated the timeframe for reporting ANE was within two hours of an incident allegation. She stated Resident #5's incident was not reported in two hours of that specific day (03/05/24) because they had problems accessing their computers and it was reported the next day (03/06/24). She stated they received further re-education from their Corporate Clinical resource Representative on the reporting requirements of reporting alleged ANE to HHSC within two hours of being notified. Interview on 03/14/24 at 1:14 pm, the OM stated Resident #5's ANE allegation was made on 03/05/24 about a black man had just come into her room and assaulted her and took her clothes off and put them back on her. He stated HHSC incidents should be submitted within two hours of being notified, but the incident of an Outside provider allegedly being abusive to Resident #5 was not reported to HHSC within two hours because there was a communication breakdown between him, and the other agency company involved as to what went down. He stated they started staff education, staff interviews, notifications with her doctor and family on 03/05/24. And he said he spoke to Administrator A on 03/06/24 about this incident and Administrator A told him to report it, then OM said he reported the incident to HHSC on 03/06/24. He stated Resident #5's alleged incident should have been reported to HHSC on 03/05/24 and the Corporate Clinical Resource Representative in-serviced himself and the DON on reporting Alleged ANE in two hours. He stated they were also instructed to notify corporate immediately on the same day to determine if something needed to be reported to HHSC. He stated he was responsible for reporting alleged ANE to HHSC and his expectations for ANE reporting was that he reported it within two hours. He stated not reporting Alleged ANE to HHSC within two hours could be a danger to a resident and they may not be safe. He stated the alleged perpetrator might still be running around unknowingly and it could be a multi factor of things that could occur. Record review of Resident #5's Provider Investigation Report revealed an allegation of sexual abuse was reported to the OM on 03/05/24 at 12:30 pm, but the OM did not report it to HHSC until 03/06/24 at 8:30 pm. Record review of the Staff Roster undated revealed OM was on the form, but the Job Title section was blank, and Administrator A was not listed on it. (continued on next page)

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Pleasant Valley Healthcare and Rehabilitation Cent	1525 Pleasant Valley Rd Garland, TX 75040

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 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Texas LTC Nursing Facility Administrator System on 03/13/24 revealed the status of OM was Prospective. Record review of the facility's Administrators Duties and Responsibilities dated 9.2017 and revised 1.2024 revealed, Policy: It is the policy of this facility that a licensed administrator shall be responsible for the day-to-day functions of the facility .Procedure: 1. Administrator A has been appointed as the facility's Administrator. 2. A. Managing the day-to-day functions of the facility .3. In absence of the Administrator, OM is authorized to act in the administrator's behalf