STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675565	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood Healthcare Community	2600 Parkview Dr Bedford, TX 76022

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48122 Based on observations, interviews, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights for 1 of 4 residents reviewed for clinical records (Resident #30). The facility failed to ensure Resident #30's use of bed rails/grab bars was documented in their care plan. The facility's failure placed residents requiring care at risk of not having their individual needs met, not receiving necessary care and services, and a failure to ensure continuity of care. Findings included: Record Review of Resident #30's Face Sheet reflected a [AGE] year-old male who initially admitted to the facility on [DATE]. Resident #30 had relevant diagnoses of personal history of traumatic brain injury (injury to the brain caused by an outside source), paroxysmal atrial fibrillation (type of irregular heartbeat that occurs in brief episodes of less than 7 days), heart failure, hypertensive heart disease with heart failure (when chronic high blood pressure causes structural and functional changes in the heart), type 2 diabetes mellitus with unspecified complications (chronic condition that occurs when the body does not use insulin properly, causing high blood sugar), cerebral infarction (when blood flow to the brain is blocked causing brain cells to die; ischemic stroke), hemiplegia (complete paralysis of one side of the body) and hemiparesis (partial weakness to one side of the body) following cerebral infarction affecting right dominant side, conversion disorder with seizures or convulsions (psychiatric illness in which psychological conflicts are manifested as physical symptoms), major depressive disorder, difficulty in walking, muscle weakness (generalized), muscle wasting and atrophy multiple sites, other symptoms and signs involving the musculoskeletal system, cognitive communication deficit (communication difficulty caused by cognitive impairment), need for assistance with personal care, pain, primary insomnia, sleep apnea, long term (current) use of anticoagulants, and other lack of coordination. Record Review of Resident #30's Quarterly MDS, dated [DATE], reflected a BIMS score of 6, indicating severe cognitive impairment. Resident #30 was shown to have functional limitations in range of motion of upper and lower extremities. Resident #30 utilized a manual wheelchair for mobility throughout the facility. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #30's Care Plan, last updated on 10/27/2024, reflected that Resident #30 was a fall risk and intervention approaches were to assist with all transfers and mobility, check frequently for safety, encourage activity participation, keep bed in lowest position, keep frequently used items and call light within reach, and observe fall precautions at all times. There was no mention of bed rails/grab bars as a problem or intervention approach in the care plan. Observation of Resident #30's room area and bed on 12/10/2024 at 10:40 AM, and on 12/12/2024 at 11:15 AM revealed bilateral grab bars raised on the bed. Interview on 12/10/2024 at 10:40 AM with Resident #30 revealed the grab bars were used for getting in and out of the bed as well as repositioning. Resident #30 stated he did not remember if there had been an assessment or if he was asked to consent for the grab bars but would if asked. Interview on 12/12/2024 at 10:36 AM with LVN I revealed that residents were to be assessed for safe use of grab bars or bed rails at admission. LVN I stated that each resident was different and some may have needed grab bars or even more such as bed rails but some did not, or would not be safe with the grab bars/bed rails. The nurse conducting the assessment was to obtain a signed consent from the resident or the responsible party, and if they were to refuse to sign the consent, then the resident could not have the grab bars/bed rails on the bed. LVN I stated that the admitting nurse was also responsible to document the results of each assessment so that the IDT was able to make the care plans. LVN I was not sure who was responsible for grab bars/bed rails documentation in the care plans. LVN I stated that it was very important to know why bars were on resident beds and that resident risks could range from causing accidents to residents falling. Interview on 12/12/2024 at 11:22 AM with the ADM revealed that grab bars and bed rails were utilized for repositioning purposes only. The ADM stated that nursing staff were to complete the assessment and obtain consent at admission or when the grab bars/bed rails were requested, and a lot of grab bar requests were family driven. The ADM stated that grab bars/bed rails could be included in a resident's care plan. The ADM stated that the risk of incorrectly placed bed rails/grab bars to the residents could have been detrimental to the resident and the bed rails/grab bars could have been considered a risk. Interview on 12/12/2024 at 11:58 AM with the DON revealed that bed rail/grab bar assessments were conducted by the admitting LVN. The admitting nurse was to conduct the assessment to determine if the resident would be safe and what type and length of grab bars or bed rails would have been most appropriate. Inclusion in the care plan was during the IDT meeting by the MDS nurse or the ADON. The DON stated the care plan should be checked quarterly and if an item was noticed missing before a quarterly review it should be updated at that time or reported to an ADON or the MDS nurse. Record Review of the facility's Bed Safety and Bed Rails policy (C)2001 MED-PASS, Inc. pertinent sections state: Policy Statement: Resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bed rails is prohibited unless the criteria for use of bed rails have been met. Policy Interpretation and Implementation (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment . 3. The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent 8. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent: a. The assessed medical needs that will be addressed with the use of bed rails; b. The resident's risks from the use of bed rails and how these will be mitigated; c. The alternatives that were attempted but failed to meet the resident's needs; and d. The alternatives that were considered but not attempted and the reasons.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51047 Based on observations, interviews, and record review, the facility failed to ensure each resident received adequate supervision for 1 of 2 residents (Resident #43) reviewed for accidents. The facility failed to safely transfer Resident #43 during a mechanical lift from the bed to the wheelchair. The facility failed to provide safe mechanical transfer by not ultilizing 2 staff members to perform the transfer. This failure could place residents at risk of accidents, injuries, and hospitalization . Findings included: Record review of Resident #43's face sheet revealed he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included postural kyphosis (this is a bone condition that causes the spine to be rounded), muscle weakness, and long-term use of anticoagulants (blood thinners). Record review of Resident #43's quarterly MDS dated [DATE], section GG Functional Abilities - OBRA /Interim revealed the resident required maximal assistance for chair/bed-to-chair transfer, toilet transfer and tub/shower transfer. Record review of Resident #43's care plan dated 10/4/2023 revealed the resident has declined in ADL function and one of the interventions included Hoyer (mechanical) lift with all transfers. Record review of Resident #43's physician order, dated 10/1/2024, revealed order for Hoyer lift for all transfers with assist of 2 or more. Observation on 12/10/2024 at 10:45am of CNA A during Resident #43's Hoyer lift transfer from bed to wheelchair. CNA A was observed performing the transfer by herself. CNA A was observed providing step-by-step instructions to Resident #43 to follow during the transfer. Resident #43 was transferred from the bed to wheelchair. In an interview on 12/10/2024 at 10:50 CNA A stated that this was a routine that she and Resident #43 had every morning when she used the Hoyer lift to transfer him from the bed to wheelchair. In an interview on 12/10/2024 at 2:49pm Resident #43 stated that his transfer was done 50 percent of the time with one person. He stated there have been no accidents or falls. In an interview on 12/11/2024 at 2:56pm, CNA B stated that he had worked at the facility for 11 months. He stated that Hoyer lift transfer always must be done by 2 people. He stated that's how he was trained to do it, and he had not seen any staff attempting the transfer by themselves at the facility. He stated he would report to the nurse right away if he witnessed it. He had an in-service on using the Hoyer lift back in September 2024 . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/11/2024 at 3:00pm, LVN C stated that all Hoyer lift transfers must be done by 2 people. He had not seen any staff doing the transfer by themselves. He stated if he saw that a staff member was doing it by themselves, he would approach the staff to offer help and then remind the staff that all Hoyer lift transfers must be done by 2 people. In an interview on 12/12/2024 at 10:37am, CNA A stated that when she started in October, she was precepted by a floor CNA and was told to do mechanical lift to Resident #43 for one person. She had an in-service training on 12/10/2024 and stated that the DON trained her to always perform Hoyer lifts with 2 people. In an interview on 12/12/24 at 2:20 PM with the facility's only DON, she stated the facility's mechanical lift policy stated it always must be a 2-person assist. The rationale was because it provided safety for residents, and it prevented resident falls. The DON stated she was the one that trained new staff about transfer safety and mechanical lift techniques when new staff was first hired. The new staff also had a preceptor on the floor. CNA A's preceptor trained her to do it 1-person. When asked what her intervention was for future preceptors to not provide inconsistencies in training, she stated she will provide an in-service training for mechanical (Hoyer) lift once a month instead of every 3 months. She stated that she also assessed new staff's competency by completing a competency checklist including transfer-pivot and she trained new staff on performing Hoyer lift transfer correctly. Record review of the facility's in-service training on 9/13/2024 on the Hoyer lift. CNA B and LVN C attended the training. Record review of Competency Assessment of CNA A on 10/15/2024 with the topic of Transfer-Pivot revealed Satisfactory assessment result. Record review of the facility's Job Specific Orientation Checklist for CNA A revealed she was trained on gait belt/transfer and Hoyer Lift. Record review of facility's Lift and Transfer policy. Policy stated: Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. Only staff with documented training on the safe use and care of the machines and equipment used in this facility will be allowed to lift or move residents. Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48122 Based on observations, interviews, and record review the facility failed to assess the risks and benefits of bed rails and grab bars with the resident or resident representative or obtain informed consent prior to installation for two (Resident #29 and Resident #54) of 4 resident rooms observed and reviewed for bed rails/enabler bars. The facility failed to have evidence of informed consent and assessment of the resident for risk of entrapment for bed rails or grab bars for Resident #29 and failed to have evidence of informed consent for bed rails or grab bars for Resident #54. This failure could affect residents who used bed rails/grab bars at risk of the resident not being assessed for bed rails or grab bars, resident/responsible party not being aware of the risks, and informed consent not being obtained from the resident or responsible party. Findings included: 1. Record review of Resident #29's face sheet reflected an [AGE] year-old male who initially admitted to the facility on [DATE] with most recent readmission on 02/09/2022. Resident # 29 had relevant diagnoses of chronic kidney disease stage 3, cellulitis of right lower limb, other symptoms and signs involving the musculoskeletal system, muscle wasting and atrophy, psychotic disorder with delusions due to known physiological condition, unspecified systolic (congestive) heart failure, need for assistance with personal care, cognitive communication deficit, history of falling, pressure ulcer of right buttock stage 2, unspecified dementia with unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, diabetes mellitus due to underlying condition with ketoacidosis (metabolic complication that happens when the body does not have enough insulin to allow blood sugar into cells to use as energy) without coma, type 2 diabetes mellitus without complications, other specified anxiety disorders, Alzheimer's disease, hypertensive heart disease with heart failure, and atherosclerotic (buildup of fats, cholesterol, and other substances in and on artery walls) heart disease of native coronary artery without angina pectoris. Review of Resident #29's MDS assessment (quarterly), dated 11/16/2024, reflected a BIMS score was not able to be obtained at the time of the assessment. Resident #29's Functional Limitation in Range of Motion was listed as no impairment for upper or lower extremities. Resident #29 was indicated to use a manual wheelchair for mobility. Resident #29 was indicated to need maximal assistance with shower/bathe self and moderate assistance to toileting, upper and lower body dressing, and personal hygiene. Record review of Resident #29's Care Plan, last updated 12/01/2024, revealed the resident was receiving hospice care services. Resident #29 is noted on 11/29/2024 to have declined in ADL functioning with approach (intervention) of 1/2 side rails up X2 to assist self for bed mobility and repositioning initiated on 07/26/2022. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Medical Record of Resident #29 revealed no bed rail/grab bar assessment or bed rail/grab bar signed consent form signed by the resident or resident's responsible party or noted to have verbal permission for the enabler bars. Observations on 12/10/2024 at 10:40 AM and on 12/12/2024 at 11:15 AM revealed on both occasions Resident #29's room had the resident's bed with bilateral 1/2 bed rails raised; resident was in bed asleep. Resident was unavailable for interview during attempts made due to being asleep or receiving personal care services by hospice agency. 2. Record review of Resident #54's face sheet revealed an [AGE] year-old male who admitted to the facility on [DATE]. Resident's relevant diagnoses included periprosthetic fracture around internal prosthetic right hip joint, acute kidney failure with tubular necrosis (condition that causes a lack of oxygen and blood flow to the kidneys, damaging them), functional urinary incontinence, periprosthetic fracture around internal prosthetic right knee joint, other symptoms and signs involving the musculoskeletal system, muscle wasting and atrophy, muscle weakness (generalized), neuralgia and neuritis (severe, sharp, or burning pain that follows the path of a damaged nerve), type 2 diabetes mellitus without complications, difficulty in walking not elsewhere classified, and cognitive communication deficit. Review of Resident #54's MDS assessment (admission), dated 11/02/2024, revealed a BIMS score of 12, indicating moderate cognitive impairment. Resident #54's Functional Abilities were documented to be independent with self-care activities and indoor mobility as he utilized a manual wheelchair or walker. Resident #54 was documented to need some help with stairs and functional cognition. Resident #54 was dependent for toileting, lower body dressing, and putting on/talking off footwear. Resident #54 was indicated to have been maximal assistance with shower/bathing. Personal hygiene assistance was indicated to need moderate assistance. Resident #54 was indicated to need moderate assistance with rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. Record review of Resident #54's Care Plan, dated 10/29/2024, revealed the RESIDENT was At Risk For Complications And Worsening Of Existing Wound(S) Surgical Wound To Right Hip R/T Impaired Mobility with approach (intervention) including Turn And Reposition Q 2 Hours And Prn Avoiding Pressure On Any Boney Pressure Areas. Resident #54 was also indicated to have been At Risk For Decline In Adl Function R/T Right Hip Fx with approaches (interventions) including: Observe Hip And Back Precautions At All Times, Provide assistive device for bed mobility, e.g., side rails and Turn With Assist Of Two People Every 2 Hours When In Bed. Never Bend Of Twist Torso Or Make Sudden Movements During Adl Care. Resident #54's care plan also included Resident Has Declined In Adl Function with approach (intervention) of 1/2 Side Rails Up X 2 To Assist Self For Bed Mobility And Repositioning. Review of Medical Record of Resident #54 revealed no signed bed rail/grab bar consent form signed by the resident or resident's responsible party or noted to have verbal permission for the enabler bars. Observations on 12/10/2024 at 1:35 PM and 12/12/2024 at 10:25 AM revealed Resident #54's room had the resident's bed with 1/2 bed rails raised on both sides. The resident was not in room at the time of observation on 12/12/2024. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #54 on 12/12/2024 at 10:25 AM occurred in the hallway. Resident #54 stated he did not remember if he or his son had signed any consents when he admitted to the facility from the hospital. Interview on 12/12/2024 at 11:22 AM with ADM revealed that grab bars and bed rails were utilized for repositioning purposes only. The ADM stated that nursing staff were to complete the assessment and obtain consent at admission or when the grab bars/bed rails were requested, and a lot of grab bar requests were family driven. If the resident was assessed as not able to be safe with the grab bars/bed rails, then the reason would be discussed with the resident and responsible party why the grab bars/bed rails would not be placed on the bed. The ADM stated that grab bars/bed rails could be included in a resident's care plan. The ADM stated that the risk of incorrectly placed bed rails/grab bars to residents could have been detrimental to the resident and the bed rails/grab bars could have been considered a risk. The ADM stated it was pointed out by a nursing staff member that the consent form for grab bars/bed rails was no longer showing at the end of the assessment in the EHR, but he had not had time to further investigate what had changed or happened. Interview on 12/12/2024 at 10:36 AM with LVN I revealed that residents were to be assessed for safe use of grab bars or bed rails at admission. LVN I stated that each resident was different and some may have needed grab bars or even more such as bed rails but some did not, or would not be safe with the grab bars/bed rails. The nurse conducting the assessment was to obtain signed consent from the resident or the responsible party and if they were to refuse to sign the consent then the resident could not have the grab bars/bed rails on the bed. LVN I stated that the admitting nurse was also responsible to document the results of each assessment so that the IDT was able to make the care plans. LVN I was not sure who was responsible for grab bars/bed rails documentation in the care plans beyond the IDT. LVN I stated that it was very important to know why bars were on resident beds, that the resident and responsible party should know the risks and benefits, and that resident risks could range from causing accidents to residents falling. Interview on 12/12/2024 at 11:58 AM with the DON revealed that bed rail/grab bar assessments were conducted by the admitting LVN. The admitting nurse was to conduct the assessment to determine if the resident would be safe and what type and length of grab bars or bed rails would have been most appropriate and obtain signed consent. Inclusion in the care plan was during the IDT meeting by a MDS nurse or the ADON. The DON stated the care plan should be checked quarterly and if an item was noticed missing before a quarterly review it should be updated at that time or reported to an ADON or the MDS nurse. The DON stated she did not know why there was no assessment for Resident #29 and no signed consent forms for Resident # 29 and Resident #54. Record review of the facility's provided Bed Safety and Bed Rails, (C)2001 revealed the policy statement Resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bedrails is prohibited unless the criteria for use of bed rails have been met. Policy Interpretation and Implementation item #1 states The resident's sleeping environment is evaluated by the interdisciplinary team. Policy Interpretation and Implementation item #2 states Consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Interpretation and Implementation item #10 states additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury including bed entrapment (e.g. , altered mental status, restlessness, etc.). Under the Use of Bed Rails section item #1 states . For the purpose of this policy bed rails include: a. Side rails; b. Safety rails; and c. Grab/assist bars Use of Bed Rails section item #3 stated The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. Use of Bed Rails section item #5 states If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes: a. an evaluation of the alternatives to bed rails that were attempted and how these alternatives failed to meet the resident's needs; b. the resident's risk associated with the use of bed rails; c. input from the resident and/or representative; and d. consultation with the attending physician. Use of Bed Rails section item #8 states Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent: a. The assessed medical needs that will be addressed with the use of bed rails; b. The resident's risks from the use of bed rails and how these will be mitigated; c. The alternatives that were attempted but failed to meet the resident's needs; and d. The alternatives that were considered but not attempted and the reasons.

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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. 48520 Based on observation, interview, 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 for 1 of 2 medication rooms (Med Room A) reviewed for pharmacy services. The facility failed to ensure Med Room A did not have expired insulin. This failure could place residents at risk of receiving expired medication and not having appropriate therapeutic effects. Findings included: Observation and interview of Med Room A with the DON on 12/11/24 at 07:30 AM, revealed in the fridge was an insulin pen Insulin Lispro Injection 100 units per ml. Dispensed 04/28/23. The insulin pen was dated as opened on 7/25/24 and labelled to discard 28 days after opening. Insulin pen did not reflect residents name on it. The DON stated that the insulin pen should have been discarded 28 days after opening. The DON did not state the risk to residents for having expired insulin. She stated, You are going to cite me for only one insulin that is expired? In an interview with the DON on 12/12/24 at 2:00 PM she stated the expectations were that expired or undated medications were discarded according to guidelines. She stated the risk for expired medication and undated medication was inactive medications. The DON stated all nursing staff were responsible for the medication rooms and moving forward, herself, and the ADONS will round to make sure that carts were locked, and no undated or expired medications were in the fridge. In an interview with the Administrator on 12/12/24 at 2:24 PM, he stated the expired insulin was discarded immediately. He stated the risk of expired medication was that it can be ineffective. Review of facility policy tilted Medication Labeling and Storage revised February 23, read in part reflected The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner . multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675565	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkwood Healthcare Community	2600 Parkview Dr Bedford, TX 76022

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observations, interviews, and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the medication cart for 1 of 7 medication carts (Med Cart C) and 2 of 2 medication rooms (Med Room A and Med Room B) reviewed for storage of medication. 1.The facility failed to ensure drugs and biologicals were labeled. Med Room B had unlabeled and undated TB vaccine and food was stored next to medications in the fridge. 2.The facility failed to ensure Med Cart C was kept locked or under direct observation of authorized staff in an area where residents and family could access it outside Resident #209's room. These failures of the facility to accurately label and safely secure storage of all medications places residents at risk for more than minimal harm. Findings included: 1. Observation and interview of Med Room B with LVN D on 12/11/24 at 07:39 AM, revealed House stock multiple dose TB skin vaccine with a dispensed date of 03/22/24 named Tuberculin Purified Protein Derivative, diluted Aplisol 5 TU /0.1 mL solution. The vaccine was open with cap removed, box was open, and the vaccine was undated with an open date. A yogurt was observed on the shelf nested between the insulins in the back. LVN D stated the vaccine should have had a date on it to indicate when it was opened so that they can knew when to discard it. LVN D stated she was not aware of whom did not date the vaccine. LVN D stated the vaccine was good to be used within 30 days of opening it. She stated that she would discard the vaccine right away. She stated the risk was not knowing if the vaccine would be effective to administrator causing potency ineffectiveness. LVN D stated the yogurt belonged to one of the residents. She stated she was confused about the storage of food in the same fridge as medication. She stated all nurses were responsible for dating medication when opened and all nurses were responsible for discarding expired medication accordingly. 2. Review of Resident #209's face sheet dated 12/11/24 revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses were stroke due to embolism (blockage) of the left brain, problems communicating, muscle weakness, high blood pressure, and reflux diseases. The family was the RP. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #209's care plan dated 12/02/24 revealed Resident #209 had a memory/recall problem related to stroke. The goal was the resident would improve memory/recall ability as evidenced by recalling staff names, stating he/she was in a nursing home, recognizing staff faces, etc., The interventions were providing verbal and visual reminders, to tell resident who you were, to remind resident of where she was. The care plan also reflected Resident #209 had moderate impaired vision. The goal was that the resident would not experience negative consequences of vision loss as evidenced by remaining physically safe and participating in social and selfcare activities. The interventions were to assess effects of vision loss on resident functional status, to ensure that the lenses of the glasses were clean and in good repair, and to provide adaptive equipment/materials such as large print. Observation on 12/11/24 at 07:50 AM to 08:05 AM, revealed a medication cart unlocked with the lock mechanism released to indicate it was unlocked. The medication cart was unattended. The door to Resident #209's room was almost closed, and the privacy curtain was drawn. There was a sink near the door entrance and a family member was observed washing his hands and he looked at the state surveyor and said there was someone here. RN E then came to the medication cart. In an interview with RN E on 12/11/24 at 08:05 AM, she stated she should have locked the medication cart while she was inside the room. She stated anyone could open the cart and have access to what was inside like medications and needles. She stated she left the cart open because she was only going inside the room for a short while. In an interview with the DON on 12/12/24 at 2:00 PM she stated the expectations were that expired or undated medications were discarded according to guidelines and that the medication cart was locked when not in direct eye view and when it was unattended. She stated the risk to residents was safety for unlocked medication cart and the risk for expired medication and undated medication was inactive medications. The DON stated storing food items next to medication can cause cross contamination. She stated all nursing staff were responsible for the medication rooms and moving forward, herself, and the ADONS will round to make sure that carts were locked, and no undated or expired medications were in the fridge. In an interview with the Administrator on 12/12/24 at 2:24 PM, he stated RN E told him she had just turned her back from the medication cart to say hi to the resident. He did not state the risk of leaving the cart unlocked and unattended. The Administrator stated as for the undated vaccine there was another one in the fridge that was dated and active. He stated, there was only one yogurt. Review of facility policy tilted Medication Labeling and Storage revised February 23, read in part reflected The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner . Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others . Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurses' station or other secured location. Medications are stored separately from food and are labeled accordingly .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489 Based on observation, interview, and record review, the facility failed to maintain an infection and prevention control program, designed to provide a safe, sanitary, and comfortable environment, and help prevent the development and transmission of communicable disease and infection, for two residents (Resident #2 and Resident #7) of eight residents reviewed for infection control practices. CMA F failed to perform hand hygiene between residents while alternately feeding Resident #2 and Resident #7. This failure had the potential to result in the spread of infection. Findings included: Review of Resident #2's face sheet, dated 12/12/24, reflected Resident #2 was an [AGE] year-old female, admitted on [DATE], with diagnoses of unspecified dementia, schizoaffective disorder, pain, and fall history. Review of Resident #2's Significant Change MDS assessment, dated 09/29/24, reflected she had impaired vision, and was rarely or never understood or able to understand others. The staff assessment of her cognitive skills reflected severely impaired cognition (rarely or never made decisions), and an acute change in mental status from her baseline. Resident #2 exhibited continuous inattention. The staff assessment of her mood scored 9, indicating possible mild depression. She exhibited no behavioral problems. Resident #2 used a wheelchair and required staff to meet all of her ADL needs. Review of Resident #2's care plan, dated 05/08/15 and edited 12/01/24, reflected (Resident #2) requires assist from staff with all of her meals. Review of Resident #7's face sheet, dated 12/12/24, reflected Resident #7 was a [AGE] year-old female, admitted on [DATE], with diagnoses of dementia, history of repeated falls, fractured leg and fractured hip, and need for assistance with personal care. Review of Resident #7's Quarterly MDS assessment, dated 09/13/24, reflected she was able to understand others, and be understood by others. She had highly impaired vision, and adequate hearing. Resident #7 had a BIMS score of 3, indicating severe cognitive impairment, and had an acute change in mental status from her baseline. She exhibited continuous inattention and fluctuating disorganized thinking. Resident #7 showed no indicators of depression and no behavioral problems. The document reflected Resident #7 used a wheelchair, and required supervision or touching assistance for eating, and for her helper(s) to perform more than half the effort (substantial/maximal assistance) for most other ADLs. Review of Resident #7's care plan, dated 08/14/18 and revised 09/13/24, reflected (Resident #7) is at risk for impaired nutrition related to disease process. Review of Resident #7's care plan, dated 07/13/20 and revised 09/13/24, reflected (Resident #7) HAS POTENTIAL FOR WEIGHT LOSS RELATED TO POOR APPETITE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/11/24 at 11:49 AM revealed CMA F sitting down between Resident #2 and Resident #7. She prepared Resident #2's tray, and handed Resident #7 her drink, which the resident was able to drink some of by herself. She began to feed Resident #2, then took Resident #7's drink from her, and began to feed Resident #7. She alternated feeding each resident bites of their food. Resident #7 roughly grabbed the dessert dish off her tray and appeared about to do something with it, and CMA F removed it from the resident's hand and replaced it on the tray. After the replaced the dessert dish was on the tray, she rubbed her finger across the corner of the tray, as if to wipe something off her finger, onto the tray. She continued to alternately feed the two residents, turning to face the resident she was feeding each time, until 12:00 PM when CNA G approached the table, sat next to Resident #7 and began to feed her while CMA F continued to feed Resident #2. CMA F did not perform any hand sanitation during the entire observation. An interview on 12/11/24 at 12:22 PM with CMA F revealed she was the medication aide, but she could not administer medication during meals, so she was helping out. She said she did not normally feed two people at once, but the other aide was still passing trays, so she was helping. She said it would not be good to feed one resident in front of the other, so she was doing both until CNA G came to feed one of the residents. When asked about feeding two people at once while not doing hand sanitation in between residents being an infection control issue, she said she washed her hands thoroughly before starting to feed them, and she was fully turning her body to face each resident when feeding them. She asked the state surveyor what she should do to correct the problem, because she could not just leave one resident sitting without food, while she fed another resident right in front of them. An interview on 12/11/24 at 12:30 PM with LVN H revealed she did not know if the aides had specifically been trained on how to feed two residents at the same time, but they had been trained to always use hand hygiene between feeding residents for infection control. She said it was not their normal practice to feed two residents at once. An interview on 12/12/24 at 1:59 PM with the DON revealed they avoided feeding two residents at once, as much as possible, but if they had to, they would be expected to sanitize their hands between each resident. She said they would do that in order to avoid cross contamination. An interview on 12/12/24 at 2:24 PM with the Administrator revealed if the staff had to feed two residents at once, they should sanitize their hands between residents. Review of the Assistance with Meals policy, revised 05/22, did not address hand hygiene during feeding residents. Review of the Handwashing/ Hand Hygiene policy, revised 10/23, reflected Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Policy Interpretation and Implementation: Administrative Practices to Promote Hand Hygiene: 1. Personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. (.) Indications for Hand Hygiene: 1. Hand hygiene is indicated: a. immediately before touching a resident; (.) c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment; (.) 2. Use an alcohol-based hand rub containing at least 60% alcohol for most clinical situations.