STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676243	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Remington Transitional Care of Richardson	1350 E Lookout Dr Richardson, TX 75082

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070 Based on interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, for 1 (Resident #16) of 1 resident's reviewed for dialysis. The facility failed to ensure post-dialysis assessments were completed for Resident #16 after thy returned from dialysis treatment. This failure could place residents at risk of inadequate post dialysis care. Findings included: Record review of Resident #16's, admission MDS assessment dated [DATE] reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #16 had diagnoses which included end stage renal failure (when kidneys suddenly become unable to filter waste products from blood), dependence on renal dialysis, (procedure to cleanse the blood), and Hypertension (increased blood pressure). Resident #16 had a BIMs score of 12, which reflected she was cognitively alert and oriented and able to make decisions for herself. The MDS section O related to special treatments, procedures, and programs reflected Resident #16 received dialysis. Record review of Resident #16's care plan, dated 04/26/2024, reflected Resident #16 received dialysis related to renal failure and was at risk for the potential complications related to dialysis. Needed hemodialysis to rule out end stage renal failure. Resident #16 will have no signs of complication from dialysis through next review. Obtain vital signs and weight per protocol. Report significant changes in pulse, respiration, and blood pressure to the physician. Record review of Resident #16's physician's order, dated 04/19/2024, reflected Hemodialysis every Monday, Wednesday, and Friday at 5:45 a.m. Further review reflected no orders to assess the access area prior to dialysis or post dialysis. Further review reflected orders to assess the access area prior to dialysis and after dialysis for the physician orders for the months of May 2024. (continued on next page)

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

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #16's EHR reflected inconsistent nursing documentation from 04/20/24 through 05/07/2024, regarding Resident #16's dialysis, monitoring of the resident's post-dialysis vital signs, or the assessment of the access area. Further review of the nurse's notes reflected on 04/24/24 it was documented by LVN E the resident returned from dialysis with vital signs checked and no assessment of the shunt; on 04/29/24 there was an assessment of shut after return; and on 05/01/2024 it was documented the resident returned from dialysis, but no assessment of the shunt. There were no assessments noted in the nursing progress notes about assessing the shunt from 04/20/24 through 05/07/24. Record review of Resident #16's dialysis communication forms reflected dialysis communication forms with no information on the resident's assessment and observation post-dialysis section on 04/22/2024, 04/24/2024,04/26/2024, 04/29/2024 (filled out but no assessment of the shunt), 05/01/2024, 05/03/2024, and 05/06/24 (filled out but no assessment of the shunt). Interview on 05/07/2024 at 10:30 a.m. with Resident #16 revealed when she returned from dialysis on the day shifts, the nurses did not assess her access area. Resident #16 stated she knew they were supposed to assess the access area, but they never did. The staff were sometimes busy with other responsibilities or their medication pass. Resident #16 stated she had asked, but the staff forget. She said she knew what to watch for herself, she really did not want to bother them . Interview on 05/08/2024 at 1:10 p.m. with LVN C revealed she was aware she was supposed to send Resident #16 and any dialysis residents with the dialysis communication form when she/they left for dialysis. The nurse on the next shift would collect the form when the resident returned from dialysis. LVN C stated she knew she was supposed to take the vital signs before she/they left and check to make sure the dressing on the access area was intact. LVN C stated if the access area was not assessed there could be a negative outcome, such as bleeding or infection, for the resident. LVN C stated the responsibility should be the charge nurse, but thought that the assessment should occur after dialysis, rather than before. Interview on 05/09/2024 at 11:31 a.m. with the DON revealed it was the nurses responsibility to send dialysis residents with a communication form to dialysis and get the form back when the resident returned to the facility. That was so, if there were orders from dialysis or changes, it was noted. She stated her expectation was for the nurses to perform post-dialysis assessments when the residents returned from dialysis and document on the dialysis communication forms on dialysis days. She stated failure to monitor the vital signs and access sight after dialysis, staff would not note the change of condition, bleeding, and whether the vitals were stable. The DON stated that if there were no orders given the nurses should call the physician and receive orders. It was basic nursing to know they must assess the access area before and after dialysis, as well as vital signs. She stated the risk for not assessing the vitals were that Resident #16 could be unstable and the shunt (special access used for dialysis treatment) could be bleeding. She stated the facility would do an in-service and monitor. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/08/2024 at 2:40 p.m. with LVN D revealed when there was a resident that is going to dialysis, the nurse was to assesses the resident before they leave, to include wight, vital signs, and the access area (if it is a shunt the thrill and bruit, shunt (special access used for dialysis treatment), document on the communication form. When the resident returns form dialysis the nurse should reassess the resident, that would include vital signs, the dressing on the access area and the thrill and bruit. LVN D stated failure to monitor and assess resident's post dialysis put them at risk of low blood pressure and bleeding. In an interview on 04/30/24 at 2:30 p.m. revealed the DON there was no policy available for dialysis or dialysis documentation.