STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676249	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Carlyle at Stonebridge Park	170 Stonebridge Lane Southlake, TX 76092

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on record review and interview, the facility failed to ensure at the time residents were admitted they had physician orders for the resident's immediate care for 1 (Resident #1) of 5 residents reviewed for admission orders in that RN A failed to enter physician orders for Resident #1's wound vacuum and wound care. This failure could cause the residents to have a worsening of the condition of their wounds. Findings included: Review of Resident #1's undated Admission Record revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included bone infection of sacrum, open wound to left lower leg requiring skin graft and wound vacuum, and emphysema. Review of Resident #1's baseline care plan, dated 01/10/24, indicated she was admitted for diseases and disorders of the skin, and she had no special care/treatments/procedures. Resident's #1's MDS not initiated due to resident being in the facility for 2 days. Review of Resident #1's hospital discharge paperwork, dated 01/10/24, under Additional Instructions reflected: Change Dressing Upon admission to the nursing facility, that the Prevena incisional vac be removed and disposed of and then a hospital grade wound vac be applied to the wound. The vac dressing needs to be removed carefully so that the graft is not dislodged. Cleanse the wound/graft gently with saline, pat dry with gauze. Apply a contact layer over the graft (i.e. Afaptic, Silcone, Mepitel One, etc.). Apply black granufoam to the wound. Apply skin barrier to the periwound Review of RN A's admission notefor Resident #1, dated 01/10/24, reflected: (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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[AGE] years old female patient arrived in the facility via stretcher at 1:30 pm. Patient alert and oriented x4 with forgetful. Patient history of DM, HTN, Chronic respiratory failure. Patient came from [Hospital]. Patient under the [Physician]. Head to [NAME] assessment done noted Cellulitis on bilateral lower legs. Wound vac on left lower leg. Wound Vac is working well. Redness on buttocks and me plex on for prevent further skin issue. Foley catheter intact and patent. Patient complain of pain, and pain management done by PRN medication. [Family] present in facility. Update the medication and sent to pharmacy. Patient on Heart healthy diet. Patient ate dinner and tolerated well. Call light within reach. No indication of wound care being done on admission to the facility. Review of Resident #1's physician orders revealed all medications from hospital discharge paperwork were initiated on 01/10/24. Wound vacuum and wound care orders were initiated on 01/12/24, the day the resident discharged . No indication of wound care being provided as directed in discharge paperwork. Telephone interview on 03/14//24 at 11:13 AM, RN A stated she could not recall Resident #1 in particular but stated she always inputs all hospital discharge orders, including wound care orders. RN A stated she did not know why the wound care orders were not put in for two days, unless the admitting doctor changed them. She stated the risk of not having wound care orders would be a worsening of the resident's wounds. Interview on 03/14/24 at 2:40 PM, the DON stated the admitting nurse was responsible for entering all orders from the hospital discharge paperwork allowing the attending physician to review orders and change them as needed. The DON stated there should be no reason for the admitting nurse not to put in wound care orders. The DON stated RN A's admission note indicated she applied the wound vacuum to the left lower leg. The DON agreed the note did not indicate the wound care had been done. The DON did not know how RN A would know to change the wound vacuum and provide wound care if the orders were not put in for two days. Review of the facility's policy Physician Orders, dated February 2010, reflected: Responsibility: Licensed Nursing Staff (RN/LVN) Treatment orders must contain: Agent to be used for cleansing site Medication name/strength Type of dressing Reason for use Duration Area of application.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on record reviews and interviews the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #1) of 5 residents reviewed for quality of care in that: RN-A failed to provide wound care for Resident's left lower leg wound from 1/10/24-1/12/24. This failure could lead to the resident's wound worsening. Findings included: Review of Resident #1's undated Admission Record revealed she was a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE] with diagnoses that included bone infection of sacrum, open wound to left lower leg requiring skin graft and wound vacuum, and emphysema. Review of Resident #1's baseline care plan, dated 1/10/24, indicated she was admitted for diseases and disorders of the skin, and she had no special care/treatments/procedures. Resident's MDS not initiated due to resident being in the facility for 2 days. Review of hospital discharge paperwork, dated 1/10/24, under Additional Instructions revealed: Change Dressing Upon admission to the nursing facility, that the Prevena incisional vac be removed and disposed of and then a hospital grade wound vac be applied to the wound. The vac dressing needs needs to be removed carefully so that the graft is not dislodged. Cleanse the wound/graft gently with saline, pat dry with gauze. Apply a contact layer over the graft (i.e. Afaptic, Silcone, Mepitel One, etc.). Apply black granufoam to the wound. Apply skin barrier to the periwound Review of Resident #1's physician orders revealed her wound care orders were not entered until 1/12/24, the day she discharged from the facility. Review of Resident #1's EHR revealed no documentation of any wound care being provided to the resident in the two days she was at the facility. Review of RN-A's admission note revealed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[AGE] years old female patient arrived in the facility via stretcher at 1:30pm. Patient alert and oriented x4 with forgetful. Patient history of DM, HTN, Chronic respiratory failure. Patient came from [Hospital]. Patient under the care of [Physician]. Head to [NAME] assessment done noted Cellulitis on bilateral lower legs. Wound vac on left lower leg. Wound Vac is working well. Redness on buttocks and me plex on for prevent further skin issue. Foley catheter intact and patent. Patient complain of pain, and pain management done by PRN medication. [Family] present in facility. Update the medication and sent to pharmacy. Patient on Heart healthy diet. Patient ate dinner and tolerated well. Call light within reach RN A's note did not indicate wound care was done upon arrival to the facility. Phone interview on 3/14/24 at 11:13 AM RN-A stated she could not recall Resident #1 in particular but stated she always enters all orders sent in the resident's hospital discharge paperwork. RN-A stated she could not say why the wound orders were not put in until two days later. RN-A stated any wound care would have been documented in nursing note. Interview on 3/14/24 at 2:40 PM the DON stated the admitting nurse was responsible for entering all admission orders from the hospital and the attending physician will modify them as needed. The DON agreed RN-A's note does not indicate wound care was done upon arrival to the facility. The DON stated it was unknown if there was any harm as the resident was only in the facility for two days. Interview on 3/14/24 at 2:50 PM the Social Worker stated Resident #1's family stated they were not happpy with the treatment and lack of care since the resident had been admitted and requested her help in transferring Resident #1 to another facility the resident had been to before. The Social Worker stated she made all the arangements and the transfer went very smoothly. The family transported the resident to the new facility. Review of the facility's policy on wound care, requeste from the Administrator, was not done, policy not provided prior to exit.