DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:2/6/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 675081	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <mark>10/21/2013</mark>
NAME OF PROVIDER OF SU			ESS, CITY, STATE, ZIP
GOLDEN ACRES LIVING A	AND REHABILITATION CENTE	CR 2525 CENTERV DALLAS, TX 75	
For information on the nursing	home's plan to correct this deficient	cy, please contact the nursing home or the state surv	vey agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM	EFICIENCIES (EACH DEFICIENCY MUST BE MATION)	PRECEDED BY FULL REGULATORY
F 0157	resident of situations (injury/de **NOTE- TERMS IN BRACKET Based on observation, interview a resident #1) plosician when he Resident #1) plosician when he : Resident #1 was admitted to the h on 10/16/13, While the IJ was rer harm that is not immediate jeopar monitoring the effectiveness of th by LVN B, by placing them at ris death, Findings included: Resider facility on [DATE]. Resident #1's [DIAGNOSES REDACTED]. Th living, Resident was continent of Resident #1's Care Plan, dated 07 Progress Note, dated 08/16/13 ref Resident #1 was sent to the hospi dated 08/16/13 at 11:27 AM refle more than 10 pounds with his leff and the physician would continue reflected the resident saw the Car revealed he/she took the resident member stated the doctor pulled t covered. Interview with LVN B o soiled. LVN B stated the wound v taking care of the wound. LVN B facility, on 10/15/13 at 2:00 PM r interview with LVN B, on 10/16/ swollen and 10/11/13 was the firs was taking care of it because ther contact Resident #1's physician w if he told the treatment nurse abou Administrator on 10/15/13 at 3:33 opened and his pacemaker was es ER regarding the information they stated, on 10/16/13 at approximat the first shift on Resident #1's unist a to 3:10 PM revealed he was not awa 10/13/13 at 2:40 PM, reflected he stated, on 10/16/13 at approximat the first shift on Resident #1's unist a notifying the physician and familj waytime he had an occasion to ch 3:10 PM revealed he was not awa 10/13/13 at 2:40 PM, reflected he stated on 10/13/13 when he sat notifying the physician and family enytician progress notes [REDAC change in condition. Observation and person. He had difficulty ans Resident #1's wound care reveale clearly visible. The chest wall bef facility's current policy, Change i communicated to the resident's identified on 10/16/13. The Admi requested at that time. The facility identified on 10/16/13. The Admi requested at that time. The facility identified on 10/16/13. The Admi requested at that time. The facility identified on 10/16/	t, the resident's doctor and a family member of t cline/room, etc.) that affect the resident S HAVE BEEN EDITED TO PROTECT CONFID and record review, it was determined the facility fail family member when the resident had a significan weed for skin/wound care and/or pacemakers. 1. Ly saw the resident's surgical wound had opened and the ospital and received an intravenous antibiotic. And noved on 10/21/13, the facility remained out of con- dy and a scope of pattern because the facility was (e Plan of Removal. These failures could also affect k for delayed medical care and treatment, increased it #1's Admission Record, dated 08/22/13, reflected the ressessment, dated 08/22/13, reflected the res- e functional status indicated resident required set up bowel and bladder. The section on the MDS assession '3/13, reflected only problems of falls and fall poti- lected the resident's pacemaker was being removed at via non- emergency transport for the procedure. cted he was not able to shower for one week, lift hii arm. The Note also reflected not to remove the ster to monitor. Resident #1's Physician's Note from the diologist that day. Interview with Resident #1's fam to the doctor on 09/26/13 for a check-up following he dressing back and told the him/her the pacemaker. In 10/15/13 at 3:05 PM revealed he changed Reside was opened and he could see the pacemaker. He rev stated there was nod rasing on the wound. LVN B state evere no orders on Resident #1's Treatment Admir hen he saw the opened wound, UN B state is were no orders on Resident #1's Treatment Admir hen he saw the opened wound, UN B state surveyors. The DON and Administrator revealed Re- sign or Mesident #1's dressing. CNA M revealed 10/13/13 at 10:52 AM, reflected incision site is op d and the resident was sent to the ER. Interview wit ve the wound, he called the supervisor and treatment y. LVN C did not recall Resident #1 having a dressi gick Resident #1's chest. A telephone interview with evering questions due to his severe hearing 10:85. And a condition	DENTIALITY** led to immediately consult with the tchange in physical status for one (N B failed to immediately consult with he pacemaker was clearly visible. mmediate Jeopardy (IJ) was identified pliance at a severity level of actual ontinuing to in-service staff and was the 27 residents, who were cared for infection, wound deterioration and/or he was originally admitted to the ident was a [AGE] year-old male with p assistance only for all activities of daily ment regarding cognition was blank. ential. Resident #1's Nursing and a new one was to be implanted. Resident #1's Nursing Progress Note, s left arm above his shoulder, or lift i-strips on the wound for one week, e Cardiologist, dated 09/26/13, ily member on 10/16/13 at 11:30 AM the visit of 08/16/13. The family r site looked good and to keep it nt #1's dressing on 10/11/13 because it was ealed he thought the treatment nurse was A, the treatment nurse for the entire or wound care for Resident #1. Another sident #1's surgical site was never red or ed again he thought the treatment nurse nistration Record. He revealed he did not st with his pacemaker exposed. When asked . Interview with the DON and t LVN B was aware Resident #1's wound had g. The DON stated she was contacted by the d the weekend supervisor told her about ey had started an investigation. The DON tigation. Interview with CNA M, who worked cared for him. She stated on 10/13/13 Resident #1 left on [DATE]. m with purulent drainage. The th LVN C on 10/19/13 at 11:00 AM nurse to check the wound as well as ing previously, nor did LVN C identify Resident #1's physician on 10/16/13 at gency room Physician's entry, dated was a left chest wound dehiscence by one inch with purulent (containing antibiotics. Resident #1's Hospital ED]. The Order also reflected to monitor for a te was aleft chest with his pacemaker is clean and free of drainage. The my sudden or serious change would be y and/or an acute care evaluation. The Condition Reporting, dated May 2007, on. An Immediate Jeopardy was 6 PM of the IJ an

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 675081	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/21/2013	
NAME OF PROVIDER OF S		STREET ADD	RESS, CITY, STATE, ZIP	
GOLDEN ACRES LIVING	AND REHABILITATION CENTE	ER 2525 CENTER DALLAS, TX		
For information on the nursi	ng home's plan to correct this deficient	cy, please contact the nursing home or the state su		
(X4) ID PREFIX TAG		DEFICIENCIES (EACH DEFICIENCY MUST B		
E 0157	OR LSC IDENTIFYING INFORM (continued from page 1)	MATION)		
F 0157	KK, CNA MM, CNA MMM, rev interview. All of those who attent the content. On 10/21/13 the IJ w removed. While the IJ was remov immediate jeopardy and a scope of effectiveness of the Plan of Remov where Resident #1 resided and who		vice and understood the significance of histrator and DON were notified the IJ was everity level of actual harm that is not g staff and monitoring the flected 27 residents resided on the unit	
F 0224	of residents' property. **NOTE- TERMS IN BRACKET Based on observation, interview a procedures that prohibit neglect of pacemakers. 1. LVN B failed to n pacemaker was clearly visible. 2. #1's new pacemaker and care of the (REDACTED]. 4. LVN B placed Staff failed to accurately assess R to the hospital and received an into was removed on 10/21/13, the faa jeopardy and a scope of pattern be effectiveness of the Plan of Remo- placing them at risk for delayed in Findings included: Resident #1's. [DATE]. Resident #1's MDS asse REDACTED]. The functional sta Resident was continent of bowel. Care Plan, dated 07/31/13, reflect the DON revealed the MDS Coor dated 08/16/13 reflected the resid to the hospital via non- emergence 11:27 AM reflected he was not at pounds with his left arm. The Not physician would continue to mon from getting the new pacemaker. did not transcribe the above infor physician's orders [REDACTED] his new pacemaker, surgical wou Resident #1's Nursing Progress N Resident #1's Skin Assessment, d from the Cardiologist, dated 09/2 family member on 10/16/13 at 11 the visit of 08/16/13. The family to looked good and to keep it covert providing wound care. Interview Wi on 10/14/13 at 3:40 PM with LVN on Resident #1's Lhes stated there v with LVN E, who worked the sec Resident #1's chest. Interview Wi on 10/14/13 at 3:40 PM with LVN on Resident #1's chest. Interview Wi trevealed she had not seen a dressi third shift on Resident #1's unit, r worked the third shift on Residen last week (week of 10/06/13 at 12:15 PM 10/11/13 was the first time he sav care of it because there were no o Resident #1's on 10/16/13 at 12:15 PM 10/11/13 was the first time he sav care of it because there were no o Resident #1's unit, on 10/16/13 at 3:05 stated the wound was opened and the wound. LVN B stated there y 10/15/13 at 3:30 PM revealed she LVN B, on 10/16/13 at 12:15 PM 10/11/13 was the first time he sav care of it because there were no o Resident #1's unit, on 10/16/13 at there was drainage on Resident #1's chest. 3 #1's Nurse	esident #I's skin related to his surgical wound pa ravenous antibiotic. An Immediate Jeopardy (U) litly remained out of compliance at a severity lev ecause the facility was continuing to in-service st val. These failures could also affect the 27 reside edical care and treatment, increased infection, w Admission Record, dated 08/22/13, reflected he v ssment, dated 08/29/13, reflected the resident wa tus indicated resident required set up assistance o and bladder. The section on the MDS assessment ed only problems of falls and fall potential. On 11 dinator responsible for care plans was on medical ent's pacemaker was being removed and a new or y transport for the procedure. Resident #1's Nursi ble to shower for one week, lift his left arm above e also reflected not to remove the steri-strips on t	TDENTIALITY** Tailed to implement written policies and reviewed for skin/wound care and/or sident's surgical wound had opened and the m, including interventions, for Resident Tailed to clarify and write physician's orders and without a physician's orders [REDACTED]. 5. the comment of the facility on the signal particular of the facility on the signal for one week, and the 5.20 PM revealed she received Resident #1 back seen back with the resident. LVN WW stated she the set back with the resident #1 was on the wound for one week, and the 5.20 PM revealed she received Resident #1 back seen back with the resident #1's loctor on 09/26/13 for a check-up following that day. Interview with Resident #1's loctor on 09/26/13 for a check-up following the and out think they were actually treflect an update and/or review regarding mit #1's physician's orders [REDACTED]. eet assessment of his surgical site. e wound, Resident #1's loctor on 09/26/13 for a check-up following that day. Interview with Resident #1's loctor on 09/26/13 for a check-up following that the the inn/her the pacemaker site d 09/30/13, reflected the facility was that as the him/her the pacemaker site d 09/30/13, reflected the facility was that hat he inn/her the pacemaker site d 09/30/13, reflected the facility was that the him/her hat sets hit for spice CNA stated there was a dressing the thereaden the site shith o	
	occurring within the facility. The	poncy also reflected neglect was defined as the f	anare to provide goods and services	

CENTERS FOR MEDICARI	H AND HUMAN SERVICES E & MEDICAID SERVICES		PRINTED:2/6/2014 FORM APPROVED
TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER (75091	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 10/21/2013
AME OF PROVIDER OF S	675081 UPPLIER AND REHABILITATION CENTE	STREET ADDRESS, CIT ER 2525 CENTERVILLE R	
or information on the nursin	g home's plan to correct this deficient	DALLAS, TX 75228	ev.
	SUMMARY STATEMENT OF D	DEFICIENCIES (EACH DEFICIENCY MUST BE PRECED	-
F 0226	SUMMARY STATEMENT OF E OR LSC IDENTIFYING INFORM (continued from page 2) necessary to avoid physical harm, any sudden or serious change won promptly and/or an acute care eva Change in Condition Reporting, c in condition. The facility's current breakdown. The facility's plan of R terminated and his license was ret DON, ADON LVN Y, ADON LV 3. The hospice provider for Resident #1 all residents by the nursing admin RN AA. These assessments were complete established for weekly skin assess staff including six RNs, 50 LVNs scheduled to be completed by 10/ included hand-outs and a post cor documentation of that process b. 1 with proper notification d. Head t changes g. Weekly nurse manage included: a. Change in condition 1 included: a. Change in condition 1 included: a. Change in condition 1 included: a. Change nurse skin assess findings. Hospice patients would unterviews conducted beginning of LVN E, LVN U, LVN A, RN W, LVN D, HHH, LVN III, LVN SS, LVN TT, LVN VV, LVN WV CNA AAA, CNA BBB, MA CCC, CNA DDD, CNA EEE, CN MMM, revealed they attended the in-service, except for able to identify the content of the removed. On 10/21/13 at 2:45 PM facility remained out of complian pattern because the facility was if acility's roster provided on 10/14 worked. Develop policies that prevent mi resident property. **NOTE - TERMS IN BRACKET Based on observation, interview 3 procedures that prohibit neglect o pacemakers. I. LVN B failed to nacemaker was clearly visible. 2. #1's new pacemaker and care of tt (REDACTED]. 4. LVN B placed Staff failed to accurately assess R to the hospital and received an inf was removed on 10/21/13, the fac jeopardy and a scope of pattern bi effectiveness of the Plan of Remo placing them at risk for delayed n Findings included: The facility's of would take action to protect and p detide 08/22/13,		DED BY FULL REGULATORY g, dated May 2007, reflected st for a physician visit cian. The facility's policy, would be notified of a change d all residents would be ter to identify the risk of skin kely assessments of skin would te Jeopardy was identified on lan of Removal was requested at he following: 1. LVN B was mbers were interviewed by had knowledge of Resident #1's woun a Assessments were conducted on DON LVN Z, ADON RN and ADON pound. 5. Specific schedules were -serviced all clinical began on 10/18/13 and was was completed. Training a. Wound care process and orders c. Changes in condition is for skin integrity resided. Inservice for CNAs r Hospice providers ant and monitoring of the wound on by the following: a. Reviewing are to all pressure wounds, if the wound care nurse. The rese coverage being seven days a the clinical manager to evaluate communicated to facility staff. JVN MM, LVN H, LVN E, ADON I, RN W, LVN QQ, LVN RR, LVN CNA N, CNA O, CNA M, CNA P, CNA LLL, CNA KK, CNA MM, CN/ II of those who attended were n 10/21/13 the IJ was by ded. While the JI was removed, the pardy and a scope of Plan of Removal. The t #1 resided and where LVN B LITY** low its policies and r skin/wound care and/or gical wound had opened and the g interventions, for Resident rify and write physician's orders a physician's orders a physician's orders (REDACTED). 5 te. Resident #1 was admitted ied on 10/16/13. While the IJ harm that is not immediate monitoring the ere cared for by LVN B, by orration and/or death, rted staff of the facility <i>i</i> also reflected neglect was it #1's Admission Record, MDS assessment, dated]. The functional status indicated t of bowel and bladder. lated 07/31/13, reflected only aled the MDS Coordinator 8/16/13 reflected the s sent to the hospital via non- tt 11:27 AM reflected he was not with his left arm. The Note ild continue to monitor. An
	onto a Physician's Telephone Ord #1's Care Plan, dated 07/31/13, di or surgical wound site care. All o 08/18/13 through 10/13/13 did not did not reflect his new surgical sii reflected the resident saw the Car revealed he/she took the resident member stated the doctor pulled t covered. Resident #1's Hospice V reflected he had an abrasion to hi a dressing to his chest. There wer 10/15/13 at 2:35 PM with the Hos wounds, but there was a dressing. Resident #1. They stated Residen worked the second shift on Resid evidence of swelling or infection Resident #1's unit, revealed she h	n was sent back with the resident. LVN WW stated she did 1 ler because she did not think they were actually physician's o d not reflect an update and/or review regarding his new pace f Resident #1's physician's orders [REDACTED]. Resident # t reflect assessment of his surgical site. Resident #1's Skin A te wound. Resident #1's Physician's Note from the Cardiolog diologist that day. Interview with Resident #1's family meml to the doctor on 09/26/13 for a check-up following the visit t he dressing back and told the him/her the pacemaker site loc 'isit Note Report, dated 09/30/13, reflected the facility was p s forehead and a skin tear to his right arm following a fall, b e no other hospice notes regarding skin assessment, wounds spice DON, Hospice RN and Hospice CNA revealed the Hos . The Hospice CNA stated there was a dressing, which he co t #1 enrolled in hospice on 09/06/13. Interview on 10/14/13 at the site. Interview on 10/14/13 at 3:50 PM with LVN E, w ad not seen a wound, dressing or drainage on Resident #1's c	rders [REDACTED]. Resident maker, surgical wound site, 1's Nursing Progress Notes from assessment, dated 08/19/13, ist, dated 09/26/13, ber on 10/16/13 at 11:30 AM of 08/16/13. The family ked good and to keep it roviding wound care. The Note it there was no mention of or wound care. Interview on price RN did not check the resident's vered with a towel when showered at 3:40 PM with LVN MM, who nt #1. She stated there was no yho worked the second shift on thest. Interview with CNA NNN,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 675081	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/21/2013
AME OF PROVIDER OF SU COLDEN ACRES LIVING A		STREET ADDRESS, CITY, S ER 2525 CENTERVILLE RD DALLAS, TX 75228	TATE, ZIP
-		cy, please contact the nursing home or the state survey agency.	DV FULL DECUL TODY
(X4) ID PREFIX TAG	OR LSC IDENTIFYING INFORM	DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED MATION)	BY FULL REGULATORY
F 0229	(continued from page 3) 10/18/13 at 5:40 AM revealed she there was not a dressing or anythi- changed Resident #1's dressing ou pacemaker. He revealed he thoug Interview with LVN A, the treatm regarding a wound or wound care present, revealed Resident #1's su the wound. LVN B stated again h #1's Treatment Administration Re on the resident's chest with his pa wound, LVN B replied, No. Inter knowledge that LVN B was awar over the site. The DON stated she She also stated the weekend supe Administrator revealed they had s suspended pending investigation. 8:10 AM revealed she frequently #1's dressing. CNA M revealed R had not been a dressing on the sit Resident #1's unit, on 10/16/13 at She stated there was not a dressin at 10:52 AM, reflected incision si resident was sent to the ER. Inter- called the supervisor and treatmer recall Resident #1 having a dressi chest. A telephone interview with until 10/13/13. Resident #1's eme a wound infection, and there was opening measured two inches by and treated with intravenous anit physician's orders [REDACTED] 10/15/13 at 10:00 AM revealed h due to his severe hearing loss. An approximately two inches by one pacemaker was also visible. The ' Reporting, dated May 2007, refle request for a physician visit prom physician. The facility's policy, C abysician would be notified of a d 2007 reflected all residents would thereafter to identify the risk of sl rflected weekly assessments of s rflmediate Jeopardy was identifie a Plan of Removal was requested are flocted the following: 1. LVN E staff members were interviewed t knowledge of Resident #1's wound. 3. The ho Skin Assessments were conducted ADON LVN Z, ADON RN and 4 integrity were found. 5. Specific schedules administrative staff in-service dal CNAs. In-service bagen on 10/18 the in-service for Hospice providers i clarifying orders c. Changes in co outification process for skin integ Resident #1 resided. Inservice for In-service for Hospice providers i clarifying creater complete care pta actions that can be measurated/4 **NO	e changed Resident #1's tee shirt one day last week (week of 10/ ng unusual about his chest. Interview with LVN B on 10/15/13 n 10/11/13 because it was soiled. LVN B stated the wound was of the the treatment nurse was taking care of the wound. LVN B state ent nurse for the entire facility, on 10/15/13 at 2:00 PM revealed for Resident #1. Another interview with LVN B, on 10/16/13 at regical site was never red or swollen and 10/11/13 was the first ti e thought the treatment nurse was taking care of it because there cord. He revealed he did not contact Resident #1's physician wh cemaker exposed. When asked if he told the treatment nurse abo view with the DON and Administrator on 10/15/13 at 3:30 PM T e the resident's wound had opened and his pacemaker was expose vas contacted by the ER regarding the information they receive rvisor told her about the wound after the arrival of the surveyors, started an investigation. The DON stated, on 10/16/13 at approxi Interview with CNA M, who worked the first shift on Resident + cared for him. She stated on 10/13/13 she notified LVN C there eisdent #1 usually would not take off his tee shirt except in the s- e until Resident #1 fell on IDATE]. Interview with LVN E, who 5:10 PM revealed she had not secan a wound, dressing or drainag g on the resident after his fall on 10/07/13. Resident #1's Nurse's te is open with purulent (containing c.The physician and family were view with LVN C on 10/19/13 at 11:00 AM revealed on 10/13/1 it nurse to check the wound as well as notifying the physician ar g previously, on did LVN C i dentify anytime he had an occasi . Resident #1's hysician on 10/16/13 at 3:10 PM revealed he wa regnecy room Physician's terry, dated 10/13/13 at 2:40 PM, refle a left chest wound dehiscence (opening at a surgical site) of a po one inch with purulent (containing pus) drainage. Resident #1's wound ear inch in his left chest with his pacemaker clearly visible. The che wound was clean and free of drainage. The facility's current poli- ced asy adden or serious change	tt 3:05 PM revealed he pened and he could see the ed there was no drainage. I she had no information 12:15 PM with the DON me he saw a dressing on were no orders on Resident en he saw the opened wound ut the resident's opened evealed they did not have any ed and LVN B placed a dressing d from LVN C on 10/13/13. The DON and mately 2:00 PM, LVN B was 41's unit, on 10/16/13 at was drainage on Resident hower. CNA M stated there worked the second shift on ge on Resident #1's chest. Note, dated 10/13/13 e notified and the 3 when he saw the wound, he d family. LVN C did not on to check Resident #1's s not aware of the wound ted he came to the ER with cemaker device. The as admitted to the hospital TED]. Resident #1's boservation of Resident #1 on dity answering questions e revealed an opened area st wall behind the ey, Change in Condition e resident's physician with a e would notify the when the resident's ssessments, dated May as required, and quarterly e, dated May 2007, reatment and documented. An 1/6/13 at 1:45 PM and 30ard of Nursing. 2. Other NR AA to determine if others ha tion with the family. 4. ded the DON, ADON LVN Y, No new sites of altered skin s. 6. Nursing es, 20 MAs, and 108 tot scheduled to work until for RNs, LVNs and MAs nuncation for new and tailed care plan f. s for unit staff where se of any skin condition to facility staff 7. a accomplished by nursing CTED]. b. Wound care nurses being responsible for r issues and concerns. owed up by skin assessments skin assessments by the 3:30 PM through 10/21/13 at AA, LVN C, RN V, LVN OO, f UU, CNA R, CNA Q, CNA YY, F, CNA GGG, CNA L, CNA JJJ, 'A who was scheduled to go the da tood the significance of PN were notified the IJ was actual harm that is not itoring the ents resided on the unit "** created for by LVN B, ration and/or death. minted on the unit '**

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Event ID: YL1011

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NAME OF PROVIDER OF S			SS, CITY, STATE, ZIP
	AND REHABILITATION CENTI	DALLAS, TX 752	228
For information on the nursi (X4) ID PREFIX TAG		cy, please contact the nursing home or the state surve DEFICIENCIES (EACH DEFICIENCY MUST BE F	
F 0279	OR LSC IDENTIFYING INFOR (continued from page 4)	MATION)	
F 02/3	Resident was continent of bowel Care Plan, dated 07/31/13, reflect the DON revealed the MDS Coor dated 08/16/13 reflected the resid to the hospital via non- emergend 11:27 AM reflected he was not al pounds with his left arm. The No physician would continue to mon from getting the new pacemaker, did not transcribe the above infor physician's orders [REDACTED) his new pacemaker, surgical wou Resident #1's Physician's Note fr Interview with Resident #1's fam 09/26/13 for a check-up followin told the him/her the pacemaker si worked the second shift on Resid evidence of swelling or infection Resident #1's unit, revealed she h who worked the second shift on 1 #1's chest. Interview on 10/18/13 not seen a dressing or anyth changed Resident #1's dressing o pacemaker. He revealed he thoug Interview with LVN A, the treath there was not a dressing or anyth changed Resident #1's dressing o pacemaker. He revealed he thoug Interview with LVN B stated again f #1's Treatment Administration R on the resident's chest with his pa wound, LVN B replied, No. Inter knowledge that LVN B was awar with a dressing. The DON stated She also stated the weekend supe Administrator revealed the yhad suspended pending investigation. 8:10 AM revealed she frequently #1's dressing. CNA M revealed F had not been a dressing on the sit Resident #1's unit, on 10/16/13 at She stated there was not a dressir at 10:52 AM, reflected incision s resident was sent to the ER. Inter called the supervisor and treatme recall Resident #1 having a dress chest. A telephone interview witf until 10/13/13. Resident #1's eme a wound infection, and there was opening measured two inches by one pacemaker was also visible. The Administrator recent of the in-serv uod care program along wite videntify the content of the Texas including six RNs, 50 LVNs, five be completed by 10/23/13. Staff ' and a post competency test. In-se wound care program along wite videntify the content of the in-serv 10/21/13 at 2:45 PM, the Admin remained out of compliance at a : the facility was still	and bladder. The section on the MDS assessment reg ted only problems of falls and fall potential. On 10/11 dinator responsible for care plans was on medical lei len's pacemaker was being removed and a new one v y transport for the procedure. Resident #1's Nursing ble to shower for one week, lift his left arm above his te also reflected not to remove the steri-strips on the itor. An interview with LVN WW on 10/16/13 at 5:2 She did not remember what documentation was sent mation onto a Physician's Telephone Order because - l, Resident #1's Care Plan, dated 07/31/13, did not rei and site, or surgical wound site care. All of Resident # on the Cardiologist, dated 09/26/13, reflected the res ly member on 10/16/13 at 11:30 AM revealed he/sh g the visit of 08/16/13. The family member stated the te looked good and to keep it covered. Interview on at the site. Interview on 10/14/13 at 3:50 PM with L' ad not seen a wound, dressing or drainage on Reside Resident #1's unit, on 10/14/13 at 3:55 PM revealed s at 5:30 AM with LVN I, who worked the third shift 'Is chest. Interview with LVN Bo worked the third shift 'Is chest. Interview with LVN B stated the v fn the treatment nurse was taking care of the wound- nent nurse for the entire facility, on 10/15/13 at 2:00 of ro Resident #1. Another interview with LVN B, on rugical site was never red or swollen and 10/11/13 w e thought the treatment nurse was taking care of it b ecord. He revealed he did not contact Resident #1's picemaker exposed. When asked if he told the treatmet is ethought the DON and Administrator on 10/15/13 at 2:00 or Resident #1. Another interview with LVN B, on rugical site was never red or swollen and his pacemake she was contacted by the ER regarding the informati rvisor told her about the wound after the arrival of th started an investigation. The DON stated, on 10/16/13 at 5:10 PM revealed she had not seen a wound, dressif us on the resident #1 fell on [DA7E]. Interview with L 5:10 PM revealed she had not seen a wound, dressif us on the resident #1 fell	6/13 af 3:30 PM, an interview with ave. Resident #1's Nursing Progress Note, was to be implanted. Resident #1 was sent Progress Note, dated 08/16/13 at shoulder, or lift more than 10 wound for one week, and the 20 PM revealed she received Resident #1 back back with the resident. LVN WW stated she she did not think they were actually flect an update and/or review regarding #1's physician's orders [REDACTED]. sident saw the Cardiologist that day. e took the resident to the doctor on e doctor pulled the dressing back and 10/14/13 at 3:40 PM with LVN MM, who resident #1. She stated there was no VN E, who worked the second shift on nt #1's chest. Interview with CNA NNN, she had not seen a dressing on Resident on Resident #1's unit, revealed she had ird shift on Resident #1's unit, on week of 10/06/13 through 10/12/13) and nn 10/15/13 at 3:05 PM revealed he wound was opened and he could see the LVN B stated there was no drainage. PM revealed she had no information 10/16/13 at 12:15 PM with the DON as the first time he saw a dressing on eccause there were no orders on Resident shysician when he saw the opened wound an trurse about the resident's opened at 3:30 PM revealed they did not have any rr was exposed, and LVN B covered the site ton they received from LVN C on 10/13/13. te surveyors. The DON and 3 at approximately 2:00 PM, LVN B was on Resident #1's unit, on 10/16/13 at VN C there was drainage on Resident cept in the shower. CNA M stated there .VN E, who worked the second shift on ng or drainage on Resident #1's condition. Observation of Resident #1's to heysician and family. LVN C did not ad an occasion to check Resident #1's realed he was not aware of the wound, he physician and family. LVN C did not ad an occasion to check Resident #1's condition. Observation of Resident #1's eistent #1 was areminated and his 'i
	LVN B failed to notify Resident clearly visible. 2. LVN B placed Resident #1 was admitted to the l on 10/16/13. While the IJ was ren harm that is not immediate jeopa monitoring the effectiveness of th by LVN B, by placing them at ris death. Findings included: ?217.1 the practice of nursing within the advanced practice authorization. setting for each level of nursing 1	for one (Resident #1) of 27 residents reviewed for sk #1's physician when he saw the resident's surgical would we a dressing on Resident #1's opened surgical wound we nospital and received an intravenous antibiotic. An Ir noved on $10/21/13$, the facility remained out of comp rdy and a scope of pattern because the facility was con- be Plan of Removal. These failures could also affect to k for delayed medical care and treatment, increased it. Standards of Nursing Practice. The Texas Board of State of Texas for Vocational Nurses, Registered Nt. The standards of practice establish a minimum accep icensure or advanced practice authorization. Failure t se even if no actual patient injury resulted. (1) Standards (1	bund had opened and the pacemaker was vithout a physician's orders [REDACTED]. mmediate Jeopardy (IJ) was identified pliance at a severity level of actual ontinuing to in-service staff and was the 27 residents, who were cared for infection, wound deterioration and/or f Nursing is responsible for regulating urses, and Registered Nurses with table level of nursing practice in any to meet these standards may result
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	ALTH AND HUMAN SERVICES CARE & MEDICAID SERVICES		PRINTED:2/6/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/21/2013
AME OF PROVIDER O	675081	STREET ADDRES	S, CITY, STATE, ZIP
	ING AND REHABILITATION CENTR	ER 2525 CENTERVII	LE RD
for information on the n	urging home's plan to correct this deficien	DALLAS, TX 7522 cy, please contact the nursing home or the state survey	
(X4) ID PREFIX TAG		DEFICIENCIES (EACH DEFICIENCY MUST BE PR	<u> </u>
	OR LSC IDENTIFYING INFOR	MATION)	
F 0281	conform to the Texas Nursing Pra laws, rules or regulations affectin environment for clients and other signs and symptoms; (ii) nursing events regarding client's status.(A client's condition and/or prevent of appropriate, the client's significar dated 08/22/13, reflected he was 08/29/13, reflected the resident w resident required set up assistance The section on the MDS assessm problems of falls and fall potentia pacemaker was being removed ar transport for the procedure. Resid shower for one week, lift his left reflected not to remove the steri- #1's Care Plan, dated 07/31/13, di or surgical wound site care. All o 08/18/13 through 10/13/13 did nd did not reflect his new surgical si reflected the resident saw the Car revealed he/she took the resident member stated the doctor pulled covered. Interview with LVN B of soiled. LVN B stated the wound' taking care of the wound. LVN B facility, on 10/15/13 at 2:00 PM r interview with LVN B, on 10/16/ swollen and 10/11/13 was the firs was taking care of it because ther contact Resident #1's physician w if he told the treatment nurse abo Administrator on 10/15/13 at 3:30 opened and his pacemaker was ev regarding the information they re wound after the arrival of the sur stated, on 10/16/13 at approximat the first shift on Resident #1's unit she notified LVN C there was dra tee shirt except in the shower. CN Resident #1's Nurse's Note, dated physician and family were notifie revealed on 10/13/13 when he sar notifying the physician anf famil anytime he had an occasion to ch 3:10 PM revealed he was not awa 10/13/13 at 2:40 PM, reflected the (opening at a surgical site) of a pr pus) drainage. Resident #1 was ap physician progress notes [REDA/ change in condition. Observation and person. He had difficulty ans Resident #1's Nound care revealed clearly visible. The chest wall be facility's current policy. Change i communicated to the resident's regarding wound care, dated May requiring treatment and documen notified on 10/16/13 at 1:45 the Texas State Board of Nursing 10/22/13.	services to maintain the highest well being of each	l as all federal, state, or local lement measures to promote a safe it: (i) the client's status including a members concerning significant t be required to stabilize a s of the health care team and, when sident #1's Admission Record, it #1's MDS assessment, dated CTED]. The functional status indicated ontinent of bowel and bladder. Plan, dated 07/31/13, reflected only 3 reflected the resident's it to the hospital via non- emergency 27 AM reflected he was not able to ith his left arm. The Note also ould continue to monitor. Resident w pacemaker, surgical wound site, ident #1's Nursing Progress Notes from Skin Assessment, dated 08/19/13, diologist, dated 09/26/13. a member on 10/16/13 at 11:30 AM e visit of 08/16/13. The family site looked good and to keep it #1's dressing on 10/11/13 because it was led he thought the treatment nurse was the treatment nurse for the entire wound care for Resident #1. Another lent #1's surgical site was never red or again he thought the treatment nurse tration Record. He revealed he did not with his pacemaker exposed. When asked therview with the DON and .VN B was aware the resident's wound had e DON stated she was contacted by the ER veekend supervisor told her about the 1 started an investigation. The DON ation. Interview with CNA M, who worked ed for him. She stated on 10/13/13 sident #1 usually would not take off his mit Resident #1 fell on [DATE]. with purulent drainage. The LVN C on 10/19/13 at 11:00 AM arse to check the wound as well as to previously, nor did LVN C identify esident #1's physician on 10/16/13 at toy room Physician's entry, dated s a left chest wound dehiscence y one inch with purulent (containing tibiotics. Resident #1's Hospital)]. The Order also reflected to monitor for a was alert and oriented to time, place uservation on 10/15/13 at 31:5 PM of th in his left chest with his pacemaker clean and free of drainage. The 'sudden or serious change would be ind/or an acute care evaluation. The ondition Reporting, dated May 2007, . The facility's Current policy co
	**NOTE- TERMS IN BRACKET Based on observation, interview a or maintain the highest practicabl and/or pacemakers. 1. LVN B fai and the pacemaker was clearly vi Resident #1's new pacemaker and physician's orders [REDACTED] orders [REDACTED]. 5. Staff fa Resident #1 was admitted to the I on 10/16/13] While the IJ was rer harm that is not immediate jeopan monitoring the effectiveness of th by LVN B, by placing them at ris death. Findings included: Resident facility on [DATE]. Resident #1's [DIAGNOSES REDACTED]. T living. Resident was continent of Resident #1's Care Plan, dated 07 interview with the DON revealed	S HAVE BEEN EDITED TO PROTECT CONFIDE and record review, the facility failed to provide the nec e physical well-being for one (Resident #1) of 27 resic led to notify Resident #1's physician when he saw the sible 2. Staff failed to develop and implement a Care l care of the pacemaker surgical wound site. 3. LVN W . 4. LVN B placed a dressing on Resident #1's sopened led to accurately assess Resident #1's skin related to h nospital and received an intravenous antibiotic. An Imm noved on 10/21/13, the facility remained out of compl rdy and a scope of pattern because the facility was con the Plan of Removal. These failures could also affect th k for delayed medical care and treatment, increased in at #1's Admission Record, dated 08/22/13, reflected he reside the functional status indicated resident required set up a bowel and bladder. The section on the MDS assessment (31/13, reflected only problems of falls and fall potent the MDS Coordinator responsible for care plans was of	2essary care and services to attain dents reviewed for skin/wound care resident's surgical wound had opened Plan, including interventions, for VW failed to clarify and write surgical wound pacemaker site. mediate Jeopardy (JJ) was identified iance at a severity level of actual tinuing to in-service staff and was e 27 residents, who were cared for fection, wound deterioration and/or e was originally admitted to the ent was a [AGE] year-old male with issistance only for all activities of daily nt regarding cognition was blank. tial. On 10/16/13 at 3:30 PM, an on medical leave. Resident #1's Nursing
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CENTERS FOR MEDICARE	& MEDICAID SERVICES		OMB NO. 0938-0391
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING	COMPLETED 10/21/2013
ORRECTION	NUMBER		10/21/2013
	675081	CTDEET ADDESS OFTV ST	
AME OF PROVIDER OF SU	OPPLIER	STREET ADDRESS, CITY, ST CR 2525 CENTERVILLE RD	ATE, ZIP
SEDEN ACKES LIVING A	AND REHABILITATION CENTE	DALLAS, TX 75228	
		cy, please contact the nursing home or the state survey agency.	NEW PROVINTORY
(X4) ID PREFIX TAG	OR LSC IDENTIFYING INFORM	DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED B MATION)	Y FULL REGULATORY
F 0309	(continued from page 6) Resident #1 was sent to the hospit	tal via non- emergency transport for the procedure Resident #1's N	Jursing Progress Note
F 0309	Resident #1 was sent to the hospit dated 08/16/13 at 11:27 AM refle- more than 10 pounds with his left and the physician would continue #1 back from getting the new pacc- stated she did not transcribe the al actually physician's orders [RED/ regarding his new pacemaker, sur [REDACTED]. Resident #1's Nur site. Resident #1's Skin Assessme Note from the Cardiologist, dated #1's family member on 10/16/13. TI pacemaker site looked good and t facility was providing wound care following a fall, but there was no assessment, wounds or wound car revealed the Hospice RN did not of dressing, which he covered with a Interview on 10/14/13 at 3:40 PM a dressing on Resident #1's chest. In 3:50 PM with LVN E, who worke drainage on Resident #1's chest. In 3:55 PM revealed she had not see worked the third shift on Resident CNA Q, who worked the third shi shirt one day last week (week of 1 soiled. LVN B stated the wound v taking care of the wound. LVN B on 1 soiled. LVN B stated the wound v taking care of it because there contact Resident #1's physician w if he told the treatment nurse abou Administrator on 10/15/13 at 2:00 PM r interview with LVN B, on 10/16/ swollen and 10/11/13 was the firs was taking care of it because there contact Resident #1's physician w if he told the treatment nurse abou Administrator on 10/15/13 at 3:33 opened and his pacemaker was ex regarding the information they ree wound after the arrival of the surv stated, on 10/16/13 at approximat the first shift on Resident #1's Nurse's N The physician and family were no revealed on 10/13/13 when he sav notifying the physician and family were no revealed on 10/13/13 when he sav notifying the physician and family any time he had an occasion to che 3:10 PM revealed he was not awa 10/13/13 at 2:40 PM, reflected he (opening at a surgical site) of a pa pus) drainage. Resident #1 was ad physician progress notes [REDAC change in condition. Observation and person. He had difficulty anst Resident #1's wound care revealed clearly visible. The chest wall belf following col	tal via non-emergency transport for the procedure. Resident #1's 1 cted he was not able to shower for one week, lift this left arm abov arm. The Note also reflected not to remove the steri-strips on the to monitor. An interview with LVN WW on 101/613 at 5:20 PM CTEDJ. Resident #1's Care Plan, dated 07/11/3, din ot reflect 1; gical wound site, or surgical wound site care. All of Resident #1's sing Progress Notes from 08/18/13 through 1013/13 did not reflect nt, dated 08/19/13, did not reflect his new surgical site wound. Re 09/26/13, reflected the resident saw the Cardiologist that day. Int at 11:30 AM revealed he/she took the resident to the doctor on 09/ i covered. Resident #1's Hospice Visit Note Report, dated 0 keep it covered. Resident #1's thirty reveals on other hospice ru e. Interview on 10/15/13 at 2:35 PM with the Hospice DON, Hog c. The Note reflect ah hard and abrasion to this fonehead and a skin mention of a dressing to his chest. There were no other hospice to to well when showered Resident #1's unit, revealed she had not seer netrview with CNA NNN, who worked the second shift on Resident #1's unit ted there was no evidence of swelling or infection at the site. Inter dis the second shift on Resident #1's unit, revealed she had not seer netrview with CNA NNN, who worked the second shift on Resident #1's unit, 10/15/13 at 5:30 FM revealed the changed Resident #1's dressing 01/15/13 at 5:30 FM revealed the changed Resident #1's attri- tion Resident #1's unit, on 10/18/13 at 5:40 AM revealed she cha 10/06/13 through 10/12/13) and there was not a dressing or anythin 10/15/13 at 5:05 FM revealed the changed Resident #1's tra- tter revealed she had not seen a dressing or anythin 10/15/13 at 5:00 FM vevealed check and the changed resident #1's tra- tter revealed has not normation regarding a woond or wound ac are yeight with the OND present, revealed Resident #1's unit, 10/15/13 at 3:05 FM revealed he changed resident #1's unit, 10/15/13 at 3:05 FM revealed he changed resident #1's unit, 10/15/13 at 3:05 F	e his shoulder, or lift wound for one week, revealed she received Resident with the resident. LVN WW did not think they were in update and/or review physician's orders ct assessment of his surgical sident #1's Physician's erview with Resident 26/13 for a check-up old the him/her the 09/30/13, reflected the tear to his right arm tes regarding skin bice RN and Hospice CNA e CNA stated there was a led in hospice on 09/06/13. it, revealed she had not seen view on 10/14/13 at a wound, dressing or nt #1's unit, on 10/14/13 at AM with LVN I, who hest. Interview with nged Resident #1's tee ng unusual about his n 10/11/13 because it was ht the treatment nurse was at nurse for the entire for Resident #1. Another ical site was never red or ught the treatment nurse d. He revealed he did not smaker exposed. When asked n the DON and ware the resident's wound had ls he was contacted by the ER ervisor told her about the nivestigation. The DON iew with CNA M, who worked he stated on 10/13/13 tally would not take off his it #1 fell on [DATE]. revealed she had not seen a ent after his fall on th purulent drainage. on 10/19/13 at 11:00 AM the wound dehiscence ith purulent drainage. on 10/19/13 at 3:15 PM of chest with his pacemaker e of drainage. The erious change would be tte care evaluation. The orting, dated May 2007, 's current policy in all residents with wounds inistrator and DON were ility's Plan of Removal i license was referred to Y, ADON LVN Z, ADON RN Resident #1 was changed e nursing administrative hese assessments were complet vor weekly skin ing six RNs, 50 duled to be completed by ind-outs and a post nation of that process b. oper notification d. Head nurse manager skin ng six RNs, 50 duled to her major ur eports, new physican's eas and sugicy clinical ing the daily c

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Event ID: YL1011

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If continuation sheet Page 7 of 8

	IH AND HUMAN SERVICES E & MEDICAID SERVICES		PRINTED:2/6/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 675081	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/21/2013
NAME OF PROVIDER OF			DRESS, CITY, STATE, ZIP
GOLDEN ACRES LIVING	AND REHABILITATION CENTR	ER 2525 CENTE DALLAS, TY	ERVILLE RD X 75228
	<u> </u>	cy, please contact the nursing home or the state	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF L OR LSC IDENTIFYING INFORM		BE PRECEDED BY FULL REGULATORY
	ng home's plan to correct this deficien SUMMARY STATEMENT OF E OR LSC IDENTIFYING INFOR! (continued from page 7) CNA JJJ, CNA KKK, MA S, CN CNA who was scheduled to go the day of intervi understood the significance of the DON were notified the IJ was rer of actual harm that is not immedi monitoring the effectiveness of th	DALLAS, T2 cy, please contact the nursing home or the state DEFICIENCIES (EACH DEFICIENCY MUST MATION)	X 75228 survey agency. BE PRECEDED BY FULL REGULATORY ealed they attended the in-service, except for one tify the content of the in-service and 10/21/13 at 2:45 PM , the Administrator and mained out of compliance at a severity level facility was still in-servicing staff and
FORM CMS-2567(02-99)	Event ID: YI 1011	Facility ID: 675081	If continuation sheet