STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455653	A. Building B. Wing	10/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Nursing Center	3326 Burgoyne Dallas, TX 75233

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42283 Based on observation, interview and record review the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for one of five residents (Resident #35) reviewed for reasonable accommodations. The facility failed to ensure Resident #35's call light was within reach. This failure could place residents at risk of not being able to contact staff and their needs not being met. Findings include: Record review of Resident #35's annual MDS Assessment, dated 07/15/22, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnosis included: viral hepatitis, diabetes mellitus, hyperlipidemia, malnutrition, anxiety disorder, depression, bipolar disorder, asthma, cataracts, dysphagia, and primary insomnia. Her BIMS score was 13 out of 15, which revealed she was cognitively intact. Her functional status revealed she needed extensive assistance with bed mobility, limited assistance with transfers, extensive assistance with dressing, limited assistance with eating, extensive assistance with toilet use, and extensive assistance with personal hygiene. Observation and interview of Resident #35's room on 09/12/22 at 10:54 AM revealed her call light was on the floor out of reach. She was observed laying in her bed. Resident #35 stated she did not know where her call light was located. She stated most of the time her call light was out of reach. She stated when her call light was out of reach she would wait for staff to come by her room during rounds then ask for assistance. Interview with CNA R on 09/15/22 at 03:13 PM revealed call lights were to be kept on residents' beds within reach. She stated Resident #35 was not capable of reaching her call light off the floor. She stated she did not know why Resident #35's call light was out of reach. She stated Resident #35 was capable of using the call light. She stated the purpose of call light placement was to ensure residents could reach them to request assistance with needs. She stated when Resident #35's call light is not within reach the resident cannot ask for assistance when needed. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN U on 09/15/22 at 03:23 PM revealed call lights were to be kept within the resident's reach. He stated call lights were not supposed to be on the floor. He stated all staff were responsible for ensuring residents' call lights were in place. He stated residents call lights were always in reach during his shift. He stated the purpose of call light placement was to ensure resident's were able to contact staff for help. He stated if residents' call lights were out of reach they could not call for help. Interview with the DON on 09/15/22 at 04:14 PM revealed resident calls lights were supposed to be placed within reach of the resident on their bed. She stated residents used call lights to inform staff assistance was needed. She stated all staff are responsible for ensuring call lights were within reach. She stated if a resident's call light was not in reach, the resident could not notify staff that help was needed. Interview with the Administrator on 09/15/22 revealed the facility did not have a policy regarding call lights.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42283 Based on observation, interview and record review, the facility failed to consult the resident's physician, when the resident had an injury and had the potential for requiring physical intervention and when there was a significant change in the resident's physical, mental or psychosocial status for one (Resident #167) of six residents reviewed for resident rights. The facility failed to notify the physician when Resident #167 experienced a change of condition on 09/12/22, which included a change in appearance, lethargic behavior, and vomiting resulting in hospitalization on [DATE]. On 09/28/22 at 2:30 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 09/30/22, the facility remained out of compliance at a severity level of actual harm this is not immediate jeopardy and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at the risk of not receiving appropriate medical interventions timely and effectively, which could result in severe illness, hospitalization or even death. Findings included: Record review of Resident #167's Quarterly Assessment, dated 09/06/22, revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: hypertension, diabetes mellitus, cerebrovascular accident, non-Alzheimer's dementia, hemiplegia, malnutrition, anxiety disorder, depression, asthma, primary insomnia, and dysphagia. His BIMS score was a 13 out of 15, which meant the resident was cognitively intact. His functional status revealed he required limited assistance with bed mobility, transfers, locomotion on/off unit, dressing, toilet use, and personal hygiene. He required supervision with walking in room and eating. Record review of Resident #167's care plan, undated, revealed there were no focus, goal, interventions/tasks regarding nausea and/or vomiting. Record review of Resident #167's nursing notes revealed no entries on 09/10/22 to 09/12/22 regarding resident's change of condition. Record review of Resident #167's September 2022 physician's orders revealed he was prescribed Promethazine HCL tablet 25 mg on 09/22/21. He was ordered to receive one tablet by mouth every six hours as needed for nausea and vomiting. Record review of Resident #167's September 2022 MAR revealed the resident was only administered one Promethazine HCL tablet 25mg on 09/04/22. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation and interview with Resident #167 on 09/12/22 at 11:22 AM revealed there was a dried brown splattered substance in his trash can and on the floor by his bed. His urinal contained approximately 300 ml of dark amber tinged urine. Resident #167 stated he did not feel well and fell asleep during the interview. Observation of Resident #167's room on 09/13/22 at 8:45 AM revealed there was a dried brown splatter substance: on his trash can, left side of the mattress and bed linen, floor and wall behind the head of his bed, the floor to the left side of his bed, and the wall located on the left side of his bed. He was observed laying in his bed. The surveyor informed LVN S of the observation. Observation of Resident #167 on 09/13/22 at 8:52 AM revealed the resident appeared to be sluggish and drowsy. He informed LVN S his stomach hurt, and he needed his urine checked. LVN S assessed Resident #167 and informed the resident his eyes appeared to be more yellowish, and urine was darker. She asked him if he had vomited this morning, if he experienced pain on any other parts of his body, and the last time he had a bowel movement. Resident #167 stated his stomach hurt, he vomited this morning, and had not had a bowel movement in a few days. She informed the resident the physician would be notified. Record review of Resident #167's nursing notes revealed on 09/13/22 he was sent out 911 due to vomiting up a substance that was brown in color. MD and ADON was notified. Per MD send out 911 for further evaluation and treatment written by LVN S. Interview with LVN S on 09/13/22 at 12:09 PM revealed Resident #167 had a change of condition since returning from the hospital on 09/06/22. She stated he appeared more lethargic, his eyes were more yellow, and his urine was darker. She stated she was just made aware from his previous nurse that Resident #167 vomited on 09/12/22. She stated she last worked with Resident #167 on 09/05/22. She stated she did not make rounds on residents at the beginning of her shift on 09/13/22. She stated her shift started at 07:00 AM. She stated she was not made aware Resident #167 had vomited until contacted by the state surveyor. She stated after assessing him she notified the ADON and physician. She stated she was informed by the ADON to call 911 and have Resident #167 transferred to the hospital. Interview with ADON A on 09/13/22 at 12:42 PM revealed Resident #167 had an isolated incident of vomiting on 09/04/22 and was given his PRN medication Promethazine. She stated he was ordered labs and sent to the hospital on 09/06/22. She stated he received an ultrasound on 09/08/22 and there were no abnormal results. She stated Resident #167 did not vomit on 09/12/22. She stated his urine appeared to be dark on 09/12/22. She stated Resident #167's dark colored urine has been an ongoing issue. She stated NP P was aware of his urine. She stated nurses and CNAs round on residents every 2 hours. She stated sometimes rounds were missed if the residents were not in their room. She stated the nurse was supposed to contact the nurse management of a resident's change in condition. She stated the nurse assessed the resident while the state surveyor was present, completed an SBAR, contacted the physician, and sent Resident #167 to the ER. She stated he was sent to the hospital due to vomit being brown/coffee colored and suspicion of internal bleeding. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with CNA R on 09/13/22 at 1:07 PM, revealed Resident #167 had been vomiting for the past two weeks. She stated his vomit and urine had been the same color for the past two weeks. She stated over the past few days Resident #167 appeared to be lethargic and not like himself. She stated she had informed nurses of the resident's change in condition. She stated she did not remember the nurses' names. She stated the last time he vomited a brown substance was 09/12/22. She noticed Resident #167 had vomited. She stated he informed her he was not feeling well. She stated she notified his nurse ADON B during the shift. She stated ADON B informed her to change his sheets. She stated she did not round on Resident #167 prior to surveyor observation on 09/13/22. She stated she had not rounded on him because she was meeting the needs of other residents on the hall. Interview with ADON B on 09/13/22 at 1:21 PM, revealed she was the acting charge nurse for Resident #167 during the 07:00 AM to 03:00 PM shift on 09/12/22. She stated she noticed he vomited during her morning medication pass around 8:30 AM to 9:30 AM. She stated she observed reddish brown stains on his bed and floor. She stated the resident informed her he felt nauseated. She stated she administered his PRN medication promethazine. She stated she did not notify the DON or physician because Resident #167 had only vomited once during her shift. She stated she shared the information verbally to the 03:00 PM to 11:00 PM nurse on 09/12/22. She stated she assessed him, took his vitals, and monitored his bowel sounds. She stated his vitals and bowel sounds were normal. She stated she did not complete a progress note regarding Resident #167's vomiting or assessment. She stated a progress note and assessment for Resident #167 should have been completed. She stated she did not know why a progress note or assessment was not completed. The surveyor attempted to contact the physician on 09/13/22 at 2:12 PM. Interview with the DON on 09/13/22 at 2:43 PM revealed, she was informed by one of the ADONs Resident #167 was nauseated on 09/04/22. She stated he had labs ordered and received medication for nausea on 09/05/22. She stated he was sent to the hospital on 09/06/22 due to his WBC and returned to the facility the same day. She stated he was supposed to be seen by a hematologist and oncologist per his hospital discharge paperwork. She stated Medical Records was supposed to set up Resident #167's follow up appointments with a hematologist and oncologist but had not. She stated she continued to remind Medical Records to set up Resident #167's follow up appointments. She stated she was informed by the ADONs he was sent to the hospital on 09/13/22 for vomiting a brown substance. She stated if Resident #167 had only vomited once she would have administered medication and monitored. She stated if Resident #167 had only vomited once the physician would not need to be notified. She stated Resident #167 vomiting a brown substance was considered a change in condition. She stated when Resident #167 had a change in condition, the nurse was supposed to assess, evaluate, listen to bowel sounds, and notify the physician. She stated the nurse should have contacted the physician and then followed the physician's orders. She stated the physician was aware the resident had a history of vomiting. Record review of the 24-hour nurse's report log on 09/13/22 revealed there was only one occasion of Resident #167 vomiting, dated 09/04/22. There was no documentation regarding him from 09/09/22 to 09/13/22. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with LVN T on 09/14/22 at 03:04 AM revealed, Resident #167 was still in the hospital due to vomiting the morning of 09/13/22. She stated he had a history of vomiting. She stated he vomited on 09/12/22 during the 11:00 PM to 07:00 AM shift. She stated he had complained of nausea and was administered his PRN promethazine. She stated she observed light yellow vomit on the floor by his bed. She stated she cleaned up his vomit with a towel. She stated she did not notify anyone of Resident #167 vomiting because he only vomited once during her shift. She stated she should have documented his vomiting episode. She stated she did not notify NP P or the physician. She stated she did not need to notify anyone. Record review of Resident #167's hospital paperwork, dated 09/14/22, reflected his admitted was 09/13/22 and his chief complaint was nausea/vomiting three times a day for four days. His gallbladder ultrasound revealed a mass in the right hepatic lobe measuring up to 12 cm. His assessment and plan revealed evidence of biliary obstruction 2/2 iterative growth of hepatic mass [mass causing bile blockage]. A gastroenterologist and hepatologist was consulted. Interview with NP P on 09/14/22 at 3:49 PM revealed, Resident #167 was sent to the hospital on 09/6/22 due to the nurse reporting jaundice like symptoms of the eyes (yellowish) and being more lethargic. He stated he ordered labs for the resident after returning from the hospital and had not seen the results. He stated he was not aware Resident #167's labs had not been completed. He stated he last saw Resident #167 the week of 09/05/22. He stated Resident #167 had a change in condition because the nurse reported the resident vomited brown stuff. He stated he informed the nurse to send Resident #167 to the hospital. He stated Resident #167 did not have a history of nausea or vomiting. He stated the facility had not reported to him Resident #167 had a history of vomiting or nausea. He stated his expectation was for the facility to contact him regarding Resident #167 vomiting on 09/12/22. He stated had the facility contacted him, he would have informed the facility to send Resident #167 to the hospital on 09/12/22. Record review of Resident #167's hospital paperwork, dated 09/20/22, revealed the resident had liver cancer and bile duct cancer. Record Review of Resident #167's nurse's notes, dated 09/20/22, revealed he returned to the facility on [DATE]. Record review of the facility policy, Change of Condition Notification, dated 06/2020, revealed, To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. The facility will promptly inform the resident, consult with the attending physician, and notify the resident's legal representative when the resident endures a significant change in their condition caused by, but not limited to: an injury/accident; a significant change in the resident's physical, cognitive, behavioral or functional status; a significant change in treatment; and/or a decision to transfer or discharge the resident from the facility. This was determined to be an Immediate Jeopardy (IJ) on 09/28/22 at 2:30 PM. The Administrator was notified. The Administrator was provided with the IJ template on 09/28/22 at 2:30 PM. The Facility Plan of Removal was accepted on 09/30/22. The plan of removal reflected: Summary of Details which lead to outcomes (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/12/22, annual survey was initiated at the facility. On 9/28/2022 surveyor provided an IJ Template notification that the Survey Agency has determined that a condition at the center constitute immediate jeopardy to resident health. The notification of the alleged immediate jeopardy states as follows: F580 Notify of Changes 1. The facility failed to notify the physician regarding Resident #167's change of condition. Identify residents who could be affected Current residents who reside at the facility who are experiencing a change of condition have the potential to be affected by this alleged deficient practice. The facility DON, ADON's and regional support staff began on 9/29/22 Thursday educating and monitoring for change of condition with residents through monitoring of progress notes, review of clinical dashboard and nurse huddles for early identification of change in condition in the last 30 days. No other residents were found to be affected by the alleged deficient practice. Identify responsible staff/ what action taken 1. DON received a 1:1 re-education on 9/29/2022 by the Regional Nurse Consultant , on the facility policy and procedure in the event of resident change of condition, immediate interventions, physician notification, review of 24-hour report, clinical dashboard, and conducting nurse huddles to identify changes in condition. This in-service was completed before in-servicing other staff members 2. LVN T received a 1:1 re-education on 9/29/2022 by the DON , RN, on the facility policy and procedure in the event of resident change of condition, immediate interventions, and physician notification. 3. ADON B received a 1:1 re-education on 9/29/2022 by the Regional Nurse Consultant, on the facility policy and procedure in the event of resident change of condition, immediate interventions, and physician notification. 4. DON initiated education on 9/14/2022 and re-educated on 9/29/2022 Licensed Nurses and Certified Nursing assistants on early identification signs of change in condition, initiation of SBAR, resident assessment and physician notification 5. Beginning 09/29/22 the facility DON, ADON'S and Regional Clinical Staff administered a post-test in conjunction with education provided to staff to confirm that education was effective and assist with identifying any further residents at risk using a change of condition post-test. Staff will be educated by 9.30.2022 and will be ongoing for any staff who is on leave, agency staff, prn and weekend staff. 6. Education will be conducted at the beginning of each shift so that no staff will provide direct care without the in-service. Staff members who are on leave, vacation, PRN, agency staff, and weekend staff who unable to attend will be identified and DON or designee will meet the staff prior to working shift to provide the education and will be taken off the schedule until training is received. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	7. An emergency ADHOC QAPI meeting was held today 9/29/22 with the Inter Disciplinary Team and the facility Medical Director. In-Service conducted In-service was conducted by Director of Nursing on 9/14/2022 and re-educated on 9/29/22. The in-service is on Change of Condition, Nursing assessment, Physician notification, Documentation, and Immediate implementation of interventions. The details of the in-service include: Walking Rounds Visualizing each resident during rounds at shift change Rounding every 2 hours Identifying Changes of Condition and what is considered a change of condition Immediate physician notification of Changes of condition Immediate implementation of interventions for changes of condition Documentation of changes of condition and interventions Notification of change of condition to DON/Designee The in-service was attended by licensed caregivers which include Registered Nurse, Licensed Vocational Nurse, Certified Nursing Assistants. For licensed staff who are unavailable for training on this date, they will not be allowed to return to work until training is complete. This in-service was initiated on 9/14/2022 and re-education 9/29/22. The Administrator and/or Director of Nursing will track training attendance via staff roster provided by Human Resources. Education tracking began on 09/29/2022 and ended on 9.30.2022; and will be ongoing for any staff who is on leave, agency staff, prn and weekend staff. Implementation of Changes The changes were started by the Director of Nursing. The changes were implemented effective on 9/29/2022 and will be ongoing until all staff are re-educated. DON received a 1:1 re-education on 9/29/2022 by the Regional Nurse Consultant, on the facility policy and procedure in the event of resident change of condition, immediate interventions, physician notification, review of 24-hour report, clinical dashboard, and conducting nurse huddles to identify changes in condition. The Director of Nursing will ensure competency through verbalization of understanding by staff and completion of questionnaire. Nursing staff- Registered Nurse, Licensed Practical Nurse, Certified Nursing Assistant were trained to follow the following new process: 1. Initiation of a nursing assessment with findings documented in SBAR (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Physician notification of change of condition 3. Continued monitoring and implementation of interventions per physician order. 4. Reporting directly to the DON 5. DON will discuss changes in conditions, interventions, and effectiveness of interventions in daily clinical meeting and any adverse findings will be reported immediately to the Medical Director. Staff were training started on 9/14/2022 and re-initiated on 9/29/2022 to identify changes that are outside of resident's baseline and to report those changes to nursing for immediate interventions. Monitoring Administrator/DON/Designee will monitor recommendation daily x 4weeks, daily x 2 weeks, daily x 1 week and monthly. All adverse findings will be reviewed by IDT team and reported to the Medical Director daily. Regional Nurse Consultant will review SBARs and progress notes with recommendations made to the Inter Disciplinary team weekly x4, bi-weekly x4 then monthly after for implementation of recommendations. All adverse findings will be reviewed monthly in Quality Assurance Performance Improvement Meeting. Facility Administrator, DON and/or Designee will monitor the staff understanding and competency with change of condition by utilizing a change of condition questionnaire with weekly staff meetings x 4 weeks to identify any further educational needs. The findings of progress notes, review of SBAR and observations with resident conditions and staff huddles will be reviewed weekly x 4 weeks during a facility IDT meeting. They will be audited by DON/ADON/ RNC and presented monthly at QAPI x 3 months then quarterly x 3 quarters. Involvement of Medical Director The Medical Director met with the Interdisciplinary team on 9/29/2022 and conducted an Ad HOC QAPI regarding change in conditions of residents, Physician notification, immediate implementation of interventions and prompt documentation of change of condition and intervention. The Medical Director was notified about the immediate Jeopardy on 9/29/2022 at 4:43pm, the Plan of removal was reviewed and accepted by the Medical Director on 9/29/2022 @ 7:40pm Involvement of QA An Ad Hoc QAPI meeting was held with the Medical Director, facility administrator, and director of nursing, to review plan of removal on 9/29/2022. Who is responsible for implementation of process? The Administrator Director of Nursing will be responsible for implementation of New Process. The New Process/system was started on 9/29/2022. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Monitoring of the Plan of Removal included the following: Record review of facility in-service training reports dated 09/29/22, 09/30/22, and 10/01/22 revealed staff were in-serviced regarding change of condition, notification of change, intervention, notification of MD and RP, documentation, immediate interventions, review of 24-hour progress notes, clinical dashboard, policy on change of condition, and conducting nurse huddles to identify changes of condition. Record review of facility competency test, undated, revealed staff completed quizzes regarding change of condition. Interviews were conducted on 09/29/22 starting at 5:09 PM through 10/01/22 at 12:45 PM with LVN D, CNA R, LVN U, CNA W, CNA X, CNA Y, CNA Z, CNA AA, CNA BB, LVN CC, LVN DD, and LVN EE across all three shifts, the weekend, PRN staff, and agency staff to ensure they had been properly in-serviced. All interviews revealed the staff were trained and completed a competency test regarding change of condition, notification of change, intervention, notification of MD and RP, documentation, immediate interventions, review of 24-hour progress notes, clinical dashboard, policy on change of condition, and conducting nurse huddles to identify changes of condition. Interview with ADON B on 10/01/22 at 1:46 PM revealed, upper management had not been hired at the facility long enough to correct anything that needed to be corrected. She stated documentation of Resident #167's change of condition would have caused the IJ not occur. She stated Resident #167 had a PRN medication, prior to that there were interventions carried out. She stated she did not know what interventions Resident #167 had. She stated interventions for Resident #167 were implemented prior to her working at the facility. She stated she had only worked at the facility for four days prior to survey on 09/12/22. She stated she did not know the facility's policies and procedures. She stated she was learning facility policy and procedures by taking incentive, talking to colleagues, CNAs, nurses, and residents. She stated the facility did not deserve an IJ. She stated the only non-compliance was failure to document in Resident #167's EMR. She stated she was re-educated on change of condition, notifying physician, entering orders, documenting, notifying RP, documenting in 24-hour report, and verbalize to the incoming nurse. She stated she was re-educated on SBAR (background, assess, and recommendation), the type of SBAR to complete, and document anything that was not the resident's baseline. (continued on next page)

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with the DON on 10/01/22 at 3:02 PM revealed, she supervised her staff by rounding, follow -ups, asking questions, and audits. She stated she ensured policies and procedures were followed by walking the units, talking to staff, reviewing systems in EMR, and visual rounding. She stated there was a delegation of supervision. She stated the ADONs supervise the CNAs and Nurses. She stated the ADONs follow up with the staff and the DON does an audit to ensure tasks have been completed. She stated the facility received an IJ because LVN T overshared information, ADON B provided care to Resident #167 but did not inform the incoming nurse. She stated staff had been in-served regarding change of condition, stop and watch, assess resident when a change of condition is noticed, notify physician, notify RP, document and give report, review documentation to ensure completion. She stated there was an audit tool used to follow up on residents until residents return to baseline or if it is their new baseline. She stated she looked at residents, talked to nursing staff, talked to residents, progress note review to ensure other residents had not had a change in condition. She stated she was re-educated regarding policy of change of condition, notification, and how to audit. She stated she re-educated to LVN T by discussing change of condition policy, notifying change, scenarios, change of condition form, follow physician orders, and documentation. She stated she re-educated on 09/29 to staff regarding change of condition, SBAR, quiz, asked questions. She stated she ensured agency and any new staff were in-serviced. She stated in-servicing will be conducted with oncoming staff. She stated she will monitor change of condition, monitor change of condition form, orders carried out, any new orders, audit tool, she stated regional will audit the change in condition form. She stated the EMR system will automatically trigger her a notification. She stated she will be monitoring as written in the POR. Interview with LVN T on 10/01/22 at 04:09 PM revealed, she was in-serviced regarding resident's change of condition, notifying the physician, and documenting a resident's change of condition in their EMR. She stated the reason the facility received an IJ was because the facility failed to act regarding Resident #167's change in condition. She stated the IJ would have been prevented had staff monitored Resident #167's changes in condition and notified the physician. The surveyor attempted to contact the physician on 10/01/22 at 4:15 PM. Interview with Regional Nurse Consultant on 10/01/22 at 04:20 PM revealed, she educated the DON and ADON B regarding facility policy on change in condition, notifying the physician, reviewing 24-hour report, morning meeting and talk nurses, and stand down. She stated she reviewed change in condition assessments, SBAR, talked to residents, talked to staff, reviewed dashboard in EMR, and reviewed progress notes to determine if other residents were affected by change in condition. She stated she assisted with in-servicing staff and competency test. She stated she created herself a tool to check dashboard and assessments per the POR. (continued on next page)

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	455653	A. Building B. Wing	10/01/2022

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with Administrator on 10/01/22 at 4:34 PM revealed, he ensured policies and procedures were being followed by monthly in-services, morning meeting (census, new admission) ambassador rounds (grievances, concerns, resident needs), rounds throughout the facility, corrections on the spot, infection control (face masks). He stated he supervised the DON by having afternoon stand downs, group chat with administrative staff and walked arounds with DON every Thursday. He stated the facility failed to ensure the resident received the care he needed. He stated the nurses did not document the medication and did not contact the physician. He stated fingers could be pointed at the nursing staff but all together the facility failed. He stated the documentation was not there regarding meds even though the nurse stated she did give it. He stated the MD was notified of the IJ on 09/29/22. He stated LVN T was held accountable and received a write up and education, education with nursing and every staff, every department has some interaction with the resident, ambassador program (you would see something regarding the resident), monitoring and auditing resident's change in condition, during daily QA meetings residents with change of will be discussed, each nurse will go over each resident on the hall thoroughly. The facility's Administrator was informed the Immediate Jeopardy was removed on 09/30/22 at 12:31 PM. The facility remained out of compliance at a severity level of actual harm this is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42283 Based on observation, interview and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment, which included but not limited to receiving treatment and supports for daily living safely for one of five residents (Resident #43) reviewed for environment. The facility failed to ensure Resident #43's privacy curtain was clean. This failure could place residents at risk for a diminished quality of life due to the lack of a homelike environment. Findings include: Record review of Resident #43's quarterly MDS, dated [DATE], revealed a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included diabetes mellitus, hyperlipidemia, aphasia, cerebrovascular accident, anxiety disorder, depression, psychotic disorder, asthma, primary insomnia, dysphagia, and chronic atrial fibrillation. His BIMS score was 1 out of 15, which revealed he was cognitively impaired. Observation on 09/13/22 at 2:40 PM in Resident #43's room revealed there were brown smudges on his privacy curtain. Resident #43 was non-verbal. Observation of Resident #43's room on 09/15/22 at 2:46 PM revealed brown smudges were on his privacy curtain. Interview with CNA R on 09/15/22 at 02:46 PM revealed there was something brown on Resident #43's privacy curtain. She stated the brown smudge on his privacy curtain could have been food or feces. She stated the Housekeeping Supervisor was responsible for ensuring residents' privacy curtains were clean. She stated Resident #43's privacy curtain had not been cleaned or replaced for a couple of months. She stated privacy curtains should be kept clean because of infection control and for Resident #43 to have a homelike environment. Interview with the Housekeeping Supervisor on 09/15/22 at 4:01 PM revealed she was responsible for ensuring residents' privacy curtains were cleaned. She stated privacy curtains were cleaned during deep cleaning or when she was informed a resident's privacy curtain was dirty. She did not state how frequently deep cleaning occurred. She stated she had not been informed of brown smudges on Resident #43's privacy curtain. She stated Resident #43's privacy curtain was cleaned about 30 days ago. She stated the privacy curtain was supposed to be cleaned to present a homelike environment. She stated Resident #43 having brown residue on his privacy curtain did not create a home like environment. She stated the curtain would be changed and cleaned right away. Record review of the facility policy titled Housekeeping-Resident Rooms, dated 08/2020, revealed, To promote the quality of life for residents by providing clean and sanitary living spaces. The housekeeping department coordinates the daily cleaning of all resident rooms.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42283 Based on interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for one (resident#34) of 5 residents reviewed for ADLs. The facility failed to provide bed baths consistently for Resident #34 per the facility bathing schedule. This failure placed residents at risk for poor personal hygiene, odors, and a decline in their quality of life. Findings included: Review of Resident #34's quarterly MDS assessment dated [DATE] reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: anemia, hypertension, viral hepatitis, anxiety disorder, depression, schizophrenia, insomnia, atrial fibrillation, gastro-esophageal reflux disease. Her Preferences for Customary Routine and Activities section indicated choosing between a tub bath, shower, bed bath, or sponge bath was very important. Her Functional Status section indicated she needed one person physical assistance with bathing, supervision with personal hygiene, supervision with bed mobility, and limited assistance with transfers. Resident #34's care plan (undated) reflected The resident has an ADL self-care performance deficit due to obesity, asthma, and impaired cognition; Interventions/Tasks: The resident requires 1 staff participation with bathing. Interview with Resident #34 on 10/01/22 at 08:49 AM revealed she had not had a shower since 09/28/22. She stated she needed assistance with showers because she could not stand by herself. She stated she did not remember her exact shower days because she has not been given showers consistently. She stated she had requested regular showers but did not receive them. She stated she felt bad about herself when she was not bathed. Review of the facility's shower binder for the 2nd floor revealed Resident #34 did not have any shower sheets for the past two weeks. Review of Resident #47's ADL verification from 09/17/22 through 10/01/22 revealed she had not consistently received showers. Interview with CNA R on 10/01/22 at 11:36 AM revealed there was not enough staff to provide showers regularly to residents. She stated the facility shower schedule was Monday, Wednesday, and Friday A Beds were bathed during the 7:00 AM to 3:00 PM shift and Tuesday, Thursday, and Saturday B Beds were bathed 3:00 PM to 11:00 PM. She stated residents will inform her they did not get showered during their 3:00 PM to 11:00 PM shower schedule. She stated there were times when Resident #34 was not bathed. She stated she did not remember the exact days. She stated showers help residents feel better about themselves. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the LVN U on 10/01/22 at 10:40 AM revealed residents were receiving showers or bed baths at least twice a week. He stated he encourages residents to bathe. He stated if residents refused, he documented and notified the residents' responsible party. Interview with the ADON B on 10/01/22 at 01:46 PM revealed CNAs provided a shower or bath to residents according to their shower schedule. She stated the charge nurses were responsible for ensuring residents were getting bathed. She stated the facility had shower sheets to track showers. She stated the 7:00 AM to 3:00 PM shift completed A bed showers and the 3:00 PM to 11:00 PM shift completed B bed showers. She stated A Bed residents are showered on Tuesday, Thursday, and Saturday and/or B Bed residents are showered on Monday, Wednesday, and Friday. She stated there had been no complaints from residents regarding showers. She stated when a resident refuses the CNA notified the nurse and the nurse contacted the responsible party. She stated the nurses and CNAs documented shower refusals. Interview with the DON on 10/01/22 at 03:02PM revealed the charge nurses, ADONs, and staffing coordinator were responsible for ensuring the residents received a shower or bath. Review of facility policy titled, Showering a Resident, undated, reflected a shower bath is given to the residents to provide cleanliness, comfort and to prevent body odors.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42283 Based on observation, interview and record review the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's choices for one of six (Resident #167) residents reviewed for quality of care. The facility failed to assess, implement interventions, communicate, document multiple incidents of vomiting on 09/12/22, which included a change in appearance, lethargic behavior, and vomiting resulting in hospitalization on [DATE]. On 09/28/22 at 2:30 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 09/30/22, the facility remained out of compliance at a severity level of actual harm this is not immediate jeopardy and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at the risk of not receiving appropriate medical interventions timely and effectively, which could result in severe illness, hospitalization or even death. Findings included: Record review of Resident #167's Quarterly Assessment, dated 09/06/22, revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: hypertension, diabetes mellitus, cerebrovascular accident, non-Alzheimer's dementia, hemiplegia, malnutrition, anxiety disorder, depression, asthma, primary insomnia, and dysphagia. His BIMS score was a 13 out of 15, which meant the resident was cognitively intact. His functional status revealed he required limited assistance with bed mobility, transfers, locomotion on/off unit, dressing, toilet use, and personal hygiene. He required supervision with walking in room and eating. Record review of Resident #167's care plan, undated, revealed there were no focus, goal, interventions/tasks regarding nausea and/or vomiting. Record review of Resident #167's nursing notes revealed no entries on 09/10/22 to 09/12/22 regarding resident's change of condition. Record review of Resident #167's September 2022 physician's orders revealed he was prescribed Promethazine HCL tablet 25 mg on 09/22/21. He was ordered to receive one tablet by mouth every six hours as needed for nausea and vomiting. Record review of Resident #167's September 2022 MAR revealed the resident was only administered one Promethazine HCL tablet 25mg on 09/04/22. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #167's labs, dated 09/06/22, revealed his WBC was 21.7 (white blood count reference range 3.8-10.1), RBC 4.00 (red blood count reference range 4.40-5.80), HGB 10.1 (hemoglobin reference range 13.8-17.2), HCT 10 (hematocrit reference range 41-50), MCV 75 (mean corpuscular volume reference range 81-99), MCH 25.3 (mean corpuscular hemoglobin reference range 27-33), RDW 20.8 (red blood cell distribution width reference range 11.5-14.5), PLT 610 (platelet reference range 130-400), NE# 15. 3 (neutrophil count reference range 1.8-7), LY% 13.9 (lymphocytes reference range 20-55), MO# 1.7 (monocytes high reference range 0.0-0.8), EO# 0.6 (eosinophil count reference range 0.0-0.5), BA# 0.3 (basophil reference range 0.0-0.2), IGRE 3.8 (reference range 0.0-0.5), Imm. Grans Abs. 0.8 (immature granulocyte reference range 0.0-0.1), CO2 22 (carbon dioxide reference range 23-32), BUN 27 (blood urea nitrogen reference range 6-25), and Creatinine 1.53 (reference range 0.30-1.20). Record Review of Resident #167's hospital paperwork, dated 09/06/22, revealed he had elevated white blood cell count. He was referred to a hematology and oncology specialist due to high white blood count. Observation and interview with Resident #167 on 09/12/22 at 11:22 AM revealed there was a dried brown splattered substance in his trash can and on the floor by his bed. His urinal contained approximately 300 ml of dark amber tinged urine. Resident #167 stated he did not feel well and fell asleep during the interview. Observation of Resident #167's room on 09/13/22 at 8:45 AM revealed there was a dried brown splatter substance: on his trash can, left side of the mattress and bed linen, floor and wall behind the head of his bed, the floor to the left side of his bed, and the wall located on the left side of his bed. He was observed laying in his bed. The surveyor informed LVN S of the observation. Observation of Resident #167 on 09/13/22 at 8:52 AM revealed the resident appeared to be sluggish and drowsy. He informed LVN S his stomach hurt, and he needed his urine checked. LVN S assessed Resident #167 and informed the resident his eyes appeared to be more yellowish, and urine was darker. She asked him if he had vomited this morning, if he experienced pain on any other parts of his body, and the last time he had a bowel movement. Resident #167 stated his stomach hurt, he vomited this morning, and had not had a bowel movement in a few days. She informed the resident the physician would be notified. Record review of Resident #167's nursing notes revealed on 09/13/22 he was sent out 911 due to vomiting up a substance that was brown in color. MD and ADON was notified. Per MD send out 911 for further evaluation and treatment written by LVN S. Interview with LVN S on 09/13/22 at 12:09 PM revealed Resident #167 had a change of condition since returning from the hospital on 09/06/22. She stated he appeared more lethargic, his eyes were more yellow, and his urine was darker. She stated she was just made aware from his previous nurse that Resident #167 vomited on 09/12/22. She stated she last worked with Resident #167 on 09/05/22. She stated if an incident of vomiting or not informing oncoming staff of incident could delay the care the resident receives. She stated she did not make rounds on residents at the beginning of her shift on 09/13/22. She stated her shift started at 07:00 AM. She stated she was not made aware Resident #167 had vomited until contacted by the state surveyor. She stated the reddish-brown emesis could be internal bleeding. She stated after assessing him she notified the ADON and physician. She stated she was informed by the ADON to call 911 and have Resident #167 transferred to the hospital. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with ADON A on 09/13/22 at 12:42 PM revealed Resident #167 had an isolated incident of vomiting on 09/04/22 and was given his PRN medication Promethazine. She stated he was ordered labs and sent to the hospital on 09/06/22. She stated he received an ultrasound on 09/08/22 and there were no abnormal results. She stated Resident #167 did not vomit on 09/12/22. She stated his urine appeared to be dark on 09/12/22. She stated Resident #167's dark colored urine has been an ongoing issue. She stated NP P was aware of his urine. She stated nurses and CNAs round on residents every 2 hours. She stated sometimes rounds were missed if the residents were not in their room. She stated an incident of vomiting or not informing oncoming staff of incident could delay the care the resident receives. She stated the nurse was supposed to contact the nurse management of a resident's change in condition. She stated the nurse assessed the resident while the state surveyor was present, completed an SBAR, contacted the physician, and sent Resident #167 to the ER. She stated he was sent to the hospital due to vomit being brown/coffee colored and suspicion of internal bleeding. Interview with CNA R on 09/13/22 at 1:07 PM, revealed Resident #167 had been vomiting for the past two weeks. She stated his vomit and urine had been the same color for the past two weeks. She stated over the past few days Resident #167 appeared to be lethargic and not like himself. She stated she had informed nurses of the resident's change in condition. She stated she did not remember the nurses' names. She stated the last time he vomited a brown substance was 09/12/22. She stated she noticed Resident #167's vomit on 09/12/22 during her morning rounds around 8:00 AM but did not know the specific time. She stated it had happened during the morning shift between 7:00 AM and around 8:00 AM. She stated she did not document the vomiting anywhere in her notes. She stated she informed ADON B of the resident vomiting directly after noticing. She stated there was no delay in notifying the ADON. She stated ADON B informed her to change his sheets. She stated she did not round on Resident #167 prior to surveyor observation on 09/13/22. She stated she had not rounded on him because she was meeting the needs of other residents on the hall. Interview with ADON B on 09/13/22 at 1:21 PM, revealed she was the acting charge nurse for Resident #167 during the 07:00 AM to 03:00 PM shift on 09/12/22. She stated she did not know he went to the hospital on 09/06/22 regarding similar issues. She stated she was unfamiliar with him because she had only been working at the facility for four days. She stated she noticed he vomited during her morning medication pass around 8:30 AM to 9:30 AM. She stated she observed reddish brown stains on his bed and floor. She stated the resident informed her he felt nauseated. She stated she administered his PRN medication promethazine. She stated she did not notify the DON or physician because Resident #167 had only vomited once during her shift. She stated she shared the information verbally to the 03:00 PM to 11:00 PM nurse on 09/12/22. She stated she assessed him, took his vitals, and monitored his bowel sounds. She stated his vitals and bowel sounds were normal. She stated she did not complete a progress note regarding Resident #167's vomiting or assessment. She stated a progress note and assessment for Resident #167 should have been completed. She stated she did not know why a progress note or assessment was not completed. The surveyor attempted to contact the physician on 09/13/22 at 2:12 PM. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with the DON on 09/13/22 at 2:43 PM revealed, she was informed by one of the ADONs Resident #167 was nauseated on 09/04/22. She stated he had labs ordered and received medication for nausea on 09/05/22. She stated he was sent to the hospital on 09/06/22 due to his WBC and returned to the facility the same day. She stated he was supposed to be seen by a hematologist and oncologist per his hospital discharge paperwork. She stated Medical Records was supposed to set up Resident #167's follow up appointments with a hematologist and oncologist but had not. She stated she continued to remind Medical Records to set up Resident #167's follow up appointments. The DON stated Medical Records was trying to locate a hematology and oncology specialist willing to take Resident #167's insurance. She stated she was informed by the ADONs he was sent to the hospital on 09/13/22 for vomiting a brown substance. She stated if Resident #167 had only vomited once she would have administered medication and monitored. She stated if Resident #167 had only vomited once the physician would not need to be notified. She stated Resident #167 vomiting a brown substance was considered a change in condition. She stated when Resident #167 had a change in condition, the nurse was supposed to assess, evaluate, listen to bowel sounds, and notify the physician. She stated the nurse should have contacted the physician and then followed the physician's orders. She stated the physician was aware the resident had a history of vomiting. Record review of the 24-hour nurse's report log on 09/13/22 revealed there was only one occasion of Resident #167 vomiting, dated 09/04/22. There was no documentation regarding him from 09/09/22 to 09/13/22. Interview with LVN T on 09/14/22 at 03:04 AM revealed, Resident #167 was still in the hospital due to vomiting the morning of 09/13/22. She stated he had a history of vomiting. She stated he vomited on 09/12/22 during the 11:00 PM to 07:00 AM shift. She stated he had complained of nausea and was administered his PRN promethazine. She stated she observed light yellow vomit on the floor by his bed. She stated she cleaned up his vomit with a towel. She stated she did not notify anyone of Resident #167 vomiting because he only vomited once during her shift. She stated she should have documented his vomiting episode. She stated she did not notify NP P or the physician. She stated she did not need to notify anyone. Record review of Resident #167's hospital paperwork, dated 09/14/22, reflected his admitted was 09/13/22 and his chief complaint was nausea/vomiting three times a day for four days. His gallbladder ultrasound revealed a mass in the right hepatic lobe measuring up to 12 cm. His assessment and plan revealed evidence of biliary obstruction 2/2 iterative growth of hepatic mass [mass causing bile blockage]. A gastroenterologist and hepatologist was consulted. Interview with NP P on 09/14/22 at 3:49 PM revealed, Resident #167 was sent to the hospital on 09/6/22 due to the nurse reporting jaundice like symptoms of the eyes (yellowish) and being more lethargic. He stated he ordered labs for the resident after returning from the hospital and had not seen the results. He stated he was not aware Resident #167's labs had not been completed. He stated he last saw Resident #167 the week of 09/05/22. He stated Resident #167 had a change in condition because the nurse reported the resident vomited brown stuff. He stated he informed the nurse to send Resident #167 to the hospital. He stated Resident #167 did not have a history of nausea or vomiting. He stated the facility had not reported to him Resident #167 had a history of vomiting or nausea. He stated his expectation was for the facility to contact him regarding Resident #167 vomiting on 09/12/22. He stated had the facility contacted him, he would have informed the facility to send Resident #167 to the hospital on 09/12/22. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #167's hospital paperwork, dated 09/20/22, revealed the resident had liver cancer and bile duct cancer. Record Review of Resident #167's nurse's notes, dated 09/20/22, revealed he returned to the facility on [DATE]. Record review of the facility policy, Change of Condition Notification, dated 06/2020, revealed, To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. The facility will promptly inform the resident, consult with the attending physician, and notify the resident's legal representative when the resident endures a significant change in their condition caused by, but not limited to: an injury/accident; a significant change in the resident's physical, cognitive, behavioral or functional status; a significant change in treatment; and/or a decision to transfer or discharge the resident from the facility. This was determined to be an Immediate Jeopardy (IJ) on 09/28/22 at 2:30 PM. The Administrator was notified. The Administrator was provided with the IJ template on 09/28/22 at 2:30 PM. The Facility Plan of Removal was accepted on 09/30/22. The plan of removal reflected: Summary of Details which lead to outcomes On 9/12/22, annual survey was initiated at the facility. On 9/28/2022 surveyor provided an IJ Template notification that the Survey Agency has determined that a condition at the center constitute immediate jeopardy to resident health. The notification of the alleged immediate jeopardy states as follows: F684 Quality of Care 1. The facility failed to intervene regarding Resident #167's change of condition. The facility failed to document, assess, and notify the physician regarding change of condition. F580 Notify of Changes 1. The facility failed to notify the physician regarding Resident #167's change of condition. Identify residents who could be affected Current residents who reside at the facility who are experiencing a change of condition have the potential to be affected by this alleged deficient practice. The facility DON, ADON's and regional support staff began on 9/29/22 Thursday educating and monitoring for change of condition with residents through monitoring of progress notes, review of clinical dashboard and nurse huddles for early identification of change in condition in the last 30 days. No other residents were found to be affected by the alleged deficient practice. Identify responsible staff/ what action taken (continued on next page)

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	455653	A. Building B. Wing	10/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Nursing Center	3326 Burgoyne Dallas, TX 75233

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. DON received a 1:1 re-education on 9/29/2022 by the Regional Nurse Consultant , on the facility policy and procedure in the event of resident change of condition, immediate interventions, physician notification, review of 24-hour report, clinical dashboard, and conducting nurse huddles to identify changes in condition. This in-service was completed before in-servicing other staff members 2. LVN T received a 1:1 re-education on 9/29/2022 by the DON , RN, on the facility policy and procedure in the event of resident change of condition, immediate interventions, and physician notification. 3. ADON B received a 1:1 re-education on 9/29/2022 by the Regional Nurse Consultant, on the facility policy and procedure in the event of resident change of condition, immediate interventions, and physician notification. 4. DON initiated education on 9/14/2022 and re-educated on 9/29/2022 Licensed Nurses and Certified Nursing assistants on early identification signs of change in condition, initiation of SBAR, resident assessment and physician notification 5. Beginning 09/29/22 the facility DON, ADON'S and Regional Clinical Staff administered a post-test in conjunction with education provided to staff to confirm that education was effective and assist with identifying any further residents at risk using a change of condition post-test. Staff will be educated by 9.30.2022 and will be ongoing for any staff who is on leave, agency staff, prn and weekend staff. 6. Education will be conducted at the beginning of each shift so that no staff will provide direct care without the in-service. Staff members who are on leave, vacation, PRN, agency staff, and weekend staff who unable to attend will be identified and DON or designee will meet the staff prior to working shift to provide the education and will be taken off the schedule until training is received. 7. An emergency ADHOC QAPI meeting was held today 9/29/22 with the Inter Disciplinary Team and the facility Medical Director. In-Service conducted In-service was conducted by Director of Nursing on 9/14/2022 and re-educated on 9/29/22. The in-service is on Change of Condition, Nursing assessment, Physician notification, Documentation, and Immediate implementation of interventions. The details of the in-service include: Walking Rounds Visualizing each resident during rounds at shift change Rounding every 2 hours Identifying Changes of Condition and what is considered a change of condition Immediate physician notification of Changes of condition Immediate implementation of interventions for changes of condition (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Documentation of changes of condition and interventions Notification of change of condition to DON/Designee The in-service was attended by licensed caregivers which include Registered Nurse, Licensed Vocational Nurse, Certified Nursing Assistants. For licensed staff who are unavailable for training on this date, they will not be allowed to return to work until training is complete. This in-service was initiated on 9/14/2022 and re-education 9/29/22. The Administrator and/or Director of Nursing will track training attendance via staff roster provided by Human Resources. Education tracking began on 09/29/2022 and ended on 9.30.2022; and will be ongoing for any staff who is on leave, agency staff, prn and weekend staff. Implementation of Changes The changes were started by the Director of Nursing. The changes were implemented effective on 9/29/2022 and will be ongoing until all staff are re-educated. DON received a 1:1 re-education on 9/29/2022 by the Regional Nurse Consultant, on the facility policy and procedure in the event of resident change of condition, immediate interventions, physician notification, review of 24-hour report, clinical dashboard, and conducting nurse huddles to identify changes in condition. The Director of Nursing will ensure competency through verbalization of understanding by staff and completion of questionnaire. Nursing staff- Registered Nurse, Licensed Practical Nurse, Certified Nursing Assistant were trained to follow the following new process: 1. Initiation of a nursing assessment with findings documented in SBAR 2. Physician notification of change of condition 3. Continued monitoring and implementation of interventions per physician order. 4. Reporting directly to the DON 5. DON will discuss changes in conditions, interventions, and effectiveness of interventions in daily clinical meeting and any adverse findings will be reported immediately to the Medical Director. Staff were training started on 9/14/2022 and re-initiated on 9/29/2022 to identify changes that are outside of resident's baseline and to report those changes to nursing for immediate interventions. Monitoring Administrator/DON/Designee will monitor recommendation daily x 4weeks, daily x 2 weeks, daily x 1 week and monthly. All adverse findings will be reviewed by IDT team and reported to the Medical Director daily. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Regional Nurse Consultant will review SBARs and progress notes with recommendations made to the Inter Disciplinary team weekly x4, bi-weekly x4 then monthly after for implementation of recommendations. All adverse findings will be reviewed monthly in Quality Assurance Performance Improvement Meeting. Facility Administrator, DON and/or Designee will monitor the staff understanding and competency with change of condition by utilizing a change of condition questionnaire with weekly staff meetings x 4 weeks to identify any further educational needs. The findings of progress notes, review of SBAR and observations with resident conditions and staff huddles will be reviewed weekly x 4 weeks during a facility IDT meeting. They will be audited by DON/ADON/ RNC and presented monthly at QAPI x 3 months then quarterly x 3 quarters. Involvement of Medical Director The Medical Director met with the Interdisciplinary team on 9/29/2022 and conducted an Ad HOC QAPI regarding change in conditions of residents, Physician notification, immediate implementation of interventions and prompt documentation of change of condition and intervention. The Medical Director was notified about the immediate Jeopardy on 9/29/2022 at 4:43pm, the Plan of removal was reviewed and accepted by the Medical Director on 9/29/2022 @ 7:40pm Involvement of QA An Ad Hoc QAPI meeting was held with the Medical Director, facility administrator, and director of nursing, to review plan of removal on 9/29/2022. Who is responsible for implementation of process? The Administrator Director of Nursing will be responsible for implementation of New Process. The New Process/system was started on 9/29/2022. Monitoring of the Plan of Removal included the following: Record review of facility in-service training reports dated 09/29/22, 09/30/22, and 10/01/22 revealed staff were in-serviced regarding change of condition, notification of change, intervention, notification of MD and RP, documentation, immediate interventions, review of 24-hour progress notes, clinical dashboard, policy on change of condition, and conducting nurse huddles to identify changes of condition. Record review of facility competency test, undated, revealed staff completed quizzes regarding change of condition. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interviews were conducted on 09/29/22 starting at 5:09 PM through 10/01/22 at 12:45 PM with LVN D, CNA R, LVN U, CNA W, CNA X, CNA Y, CNA Z, CNA AA, CNA BB, LVN CC, LVN DD, and LVN EE across all three shifts, the weekend, PRN staff, and agency staff to ensure they had been properly in-serviced. All interviews revealed the staff were trained and completed a competency test regarding change of condition, notification of change, intervention, notification of MD and RP, documentation, immediate interventions, review of 24-hour progress notes, clinical dashboard, policy on change of condition, and conducting nurse huddles to identify changes of condition. Interview with ADON B on 10/01/22 at 1:46 PM revealed, upper management had not been hired at the facility long enough to correct anything that needed to be corrected. She stated documentation of Resident #167's change of condition would have caused the IJ not occur. She stated Resident #167 had a PRN medication, prior to that there were interventions carried out. She stated she did not know what interventions Resident #167 had. She stated interventions for Resident #167 were implemented prior to her working at the facility. She stated she had only worked at the facility for four days prior to survey on 09/12/22. She stated she did not know the facility's policies and procedures. She stated she was learning facility policy and procedures by taking incentive, talking to colleagues, CNAs, nurses, and residents. She stated the facility did not deserve an IJ. She stated the only non-compliance was failure to document in Resident #167's EMR. She stated she was re-educated on change of condition, notifying physician, entering orders, documenting, notifying RP, documenting in 24-hour report, and verbalize to the incoming nurse. She stated she was re-educated on SBAR (background, assess, and recommendation), the type of SBAR to complete, and document anything that was not the resident's baseline. Interview with the DON on 10/01/22 at 3:02 PM revealed, she supervised her staff by rounding, follow -ups, asking questions, and audits. She stated she ensured policies and procedures were followed by walking the units, talking to staff, reviewing systems in EMR, and visual rounding. She stated there was a delegation of supervision. She stated the ADONs supervise the CNAs and Nurses. She stated the ADONs follow up with the staff and the DON does an audit to ensure tasks have been completed. She stated the facility received an IJ because LVN T overshared information, ADON B provided care to Resident #167 but did not inform the incoming nurse. She stated staff had been in-served regarding change of condition, stop and watch, assess resident when a change of condition is noticed, notify physician, notify RP, document and give report, review documentation to ensure completion. She stated there was an audit tool used to follow up on residents until residents return to baseline or if it is their new baseline. She stated she looked at residents, talked to nursing staff, talked to residents, progress note review to ensure other residents had not had a change in condition. She stated she was re-educated regarding policy of change of condition, notification, and how to audit. She stated she re-educated to LVN T by discussing change of condition policy, notifying change, scenarios, change of condition form, follow physician orders, and documentation. She stated she re-educated on 09/29 to staff regarding change of condition, SBAR, quiz, asked questions. She stated she ensured agency and any new staff were in-serviced. She stated in-servicing will be conducted with oncoming staff. She stated she will monitor change of condition, monitor change of condition form, orders carried out, any new orders, audit tool, she stated regional will audit the change in condition form. She stated the EMR system will automatically trigger her a notification. She stated she will be monitoring as written in the POR. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with LVN T on 10/01/22 at 04:09 PM revealed, she was in-serviced regarding resident's change of condition, notifying the physician, and documenting a resident's change of condition in their EMR. She stated the reason the facility received an IJ was because the facility failed to act regarding Resident #167's change in condition. She stated the IJ would have been prevented had staff monitored Resident #167's changes in condition and notified the physician. The surveyor attempted to contact the physician on 10/01/22 at 4:15 PM. Interview with Regional Nurse Consultant on 10/01/22 at 04:20 PM revealed, she educated the DON and ADON B regarding facility policy on change in condition, notifying the physician, reviewing 24-hour report, morning meeting and talk nurses, and stand down. She stated she reviewed change in condition assessments, SBAR, talked to residents, talked to staff, reviewed dashboard in EMR, and reviewed progress notes to determine if other residents were affected by change in condition. She stated she assisted with in-servicing staff and competency test. She stated she created herself a tool to check dashboard and assessments per the POR. Interview with Administrator on 10/01/22 at 4:34 PM revealed, he ensured policies and procedures were being followed by monthly in-services, morning meeting (census, new admission) ambassador rounds (grievances, concerns, resident needs), rounds throughout the facility, corrections on the spot, infection control (face masks). He stated he supervised the DON by having afternoon stand downs, group chat with administrative staff and walked arounds with DON every Thursday. He stated the facility failed to ensure the resident received the care he needed. He stated the nurses did not document the medication and did not contact the physician. He stated fingers could be pointed at the nursing staff but all together the facility failed. He stated the documentation was not there regarding meds even though the nurse stated she did give it. He stated the MD was notified of the IJ on 09/29/22. He stated LVN T was held accountable and received a write up and education, education with nursing and every staff, every department has some interaction with the resident, ambassador program (you would see something regarding the resident), monitoring and auditing resident's change in condition, during daily QA meetings residents with change of will be discussed, each nurse will go over each resident on the hall thoroughly. The facility's Administrator was informed the Immediate Jeopardy was removed on 09/30/22 at 12:31 PM. The facility remained out of compliance at a severity level of actual harm this is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42283 Based on interview and record review the facility failed to ensure that residents received proper treatment and assistive devices to maintain vision and hearing abilities o for 1 of 1 resident (Resident #10) reviewed for vision and hearing devices. The facility failed to ensure Resident #10 received eyeglasses to correct his vision. This failure could place residents at risk of falls due to not being able to see. Findings include: Record review of Resident #10's face sheet revealed the resident was admitted to the facility on [DATE] with diagnoses which included: hemiplegia following cerebral infarction affecting right dominant side (right-sided paralysis after stroke), insomnia (difficulty sleeping), osteomyelitis (softening of bones), repeated falls, dysphagia (difficulty speaking and swallowing), dysarthria (problems with joints), apraxia (problems moving around), malnutrition, muscle wasting and atrophy, lack of coordination, difficulty walking, pulmonary hypertension (high pressure in the veins and arteries of the lungs), congestive heart failure (heart disease), emphysema (disease of lungs), unsteadiness on feet, major depressive disorder, hypertension (high blood pressure), myocardial infarction (heart attack). Record review of the MDS assessment on 9/07/22 by SW indicated vision adequate with no need for corrective lenses. Record review of care plan, dated 9/07/22, indicated no eye/vision problems had been identified as a care planning need. In an interview on 09/12/22 at 12:32 PM with Resident #10, revealed the resident needed glasses. Resident #10 said he had discussed this need in the resident council meeting. In an interview on 09/13/22 at 01:37 PM with the Social Worker revealed she was not aware Resident #10's needed glasses. The Social Worker said, if a resident had issues with their vision They will either put a note under my door or bring up the problem to a nurse or social worker. We work what comes to us. Social Worker stated she was part of the care plan meeting. She stated Resident #10 was not mentioned in the care plan meeting. The Social Worker stated they sometimes found out about these problems in the care plan meeting. The Social Worker stated if residents didn't get their vision problems treatedthen their needs were not being met . In an interview on 09/14/22 at 02:40 PM with MDS K/MDS coordinator, revealed it was important to do an accurate MDS assessments because it captured an accurate picture of that resident at that point in time. In an interview on 09/15/22 at 09:00 AM with ADON L, revealed if a resident needed glasses and didn't get themIt could cause them headaches from eye strain, they could have a fall and injure themselves. ADOL L stated she was not aware Resident #10 needed glasses. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/15/22 at 02:42 PM with the Administrator, revealed Social Services had the responsibility for ensuring residents got glasses when they needed them. The Administrator said, If a resident's eyesight is impaired you run the risk for fall and injury, and diminished quality of life. Record review of the facility policy, dated 08/2020 , titled, Referrals to Outside Services read in part, The Director of Social Services coordinates the referral of residents to outside agencies/programs to fulfill resident needs for services not offered by the Facility.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42283 Based on observation, interview and record review the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the residents clinical condition demonstrated that it was not possible or the resident's preferences indicated otherwise for one of six resident (Resident #167) reviewed for weight loss and nutrition. The facility failed to ensure Resident #167 had appropriate interventions in place to prevent a significant weight loss. Resident #167 had a weight loss of 5.40% in one month and 12.92% in six months. The failure could place the residents at risk of health complication and decreased mobility. Findings include: Record review of Resident #167's quarterly MDS Assessment, dated 09/06/22, revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included: hypertension, diabetes mellitus, cerebrovascular accident, non-Alzheimer's dementia, hemiplegia, malnutrition, anxiety disorder, depression, asthma, primary insomnia, and dysphagia. His BIMS score was a 13 out of 15, which meant he was cognitively intact. Record review of Resident #167's, undated, care plan revealed he had the potential for a nutritional problem and was at risk for weight loss related to CVA, dysphagia, dementia, COPD, DM. He received a regular diet, mechanical soft texture with thin liquids. His goal was to maintain adequate nutritional status as evidenced by maintaining weight, no diagnosis of malnutrition, and consuming at least 50% of at least 3 meals daily through the review date [undated]. His interventions were to monitor/document/report to MD PRN for diagnosis of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. Monitor/document/report to MD PRN diagnosis of malnutrition: emaciation (cachexia), muscle wasting, significant weight loss: 3lbs in 1 week, >5% in a month, >7.5% in 3 months, >10% in 6 months. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Provide, serve diet as ordered. Monitor intake and record Q meal. RD to evaluate and make diet change recommendations PRN. Record review of Resident #167's weight, in his clinical chart, reflected the following entries: 04/2022 - 161lbs. 05/2022 - 154 lbs. 06/2022 - 153.2 lbs. 07/2022 - 151.0 lbs. 08/2022 - 148.2 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/05/22 - 140.2 lbs. Record review of Resident #167's September 2022 Physician Orders reflected, regular diet mechanical soft texture, thin consistency. Record review of Resident #167's Nutrition assessment dated [DATE], revealed no further recommendations at this time and was signed by the Register Dietician. An observation and interview of Resident #167 on 09/12/22 at 1:00 PM revealed he did not finish eating his lunch. He stated he was tired and not feeling well. The resident went to sleep. An interview with ADON on 09/13/22 at 12:42 PM revealed the Restorative Aide was responsible for weighing all residents. She stated the DON reviewed the weights and the ADONs documented the weights in the residents' EMR. She stated the EMR triggered a resident's weight loss. She stated the Registered Dietician had access to the EMR and was able to see when a resident had a weight loss. She stated Resident #167's weight loss had been trending down for the last two months. She stated the RD had been made aware of Resident #167's weight loss. She stated there were no weight loss interventions in place until the RD completes Resident #167's weight loss recommendations. An interview with Restorative Aide on 09/13/22 at 01:38 PM revealed she was responsible for weighing all residents. She stated residents were weighed as ordered. She stated residents were weighed upon admission, weekly and monthly. She stated she reported resident weights to the DON every morning. The DON informed her when a resident had a weight loss of 5 lbs. or more and needed to be reweighed. She stated if a resident had a weight loss the DON informed the Registered Dietician. She stated Resident #167 lost weight but she did not know how much. She stated he was consistently losing weight every month due to his diagnosis. She did not disclose his diagnosis contributing to weight loss. An interview with the RD on 09/13/22 at 02:22 PM revealed she was aware Resident #167 had lost weight. She stated Resident #167 triggered for weight loss for the month of September. She stated she had not completed her September monthly recommendations for residents. She stated she was waiting on the facility to complete all residents' weights before September monthly recommendations were completed. She stated she had not seen Resident #167 because he was sent to the hospital on 09/06/22 due to a change in condition and returned later that evening. She stated after all residents' weights were completed, she would run a monthly report, then calculate the residents' percentage of weight loss, and inform the facility what residents had a significant weight loss. She stated Resident #167 was on her list for weight loss. She stated she was going to have the nurse reweigh him on 09/13/22 but he was sent to the hospital. She stated she was informed of Resident #167's weight loss this week. She stated residents were seen at admission, annually, weight loss, and/or if they had wounds. She stated she had not seen Resident #167 since 03/2022 and had not triggered him for weight loss. She stated there were no risks to the Resident #167 because he was going to be seen later during the month of September. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the DON on 09/13/21 at 02:43 PM revealed Resident #167 was weighed monthly and experienced a weight loss on 09/05/22. She stated the Registered Dietician had not seen Resident #167 for September's weight loss. She stated he was going to be evaluated by the Registered Dietician but was sent to the hospital on 09/13/22. She stated significant weight loss was considered 5% at one month, 7.5% at three months, and 10% at six months. She stated the resident had not had a significant weight loss. She stated she did not know why the resident was losing weight. She stated she did not know how much weight the resident had lost. She stated she could not say rather Resident #167's weight loss could have been avoided. She stated the resident was not receiving any weight loss interventions because he had not been seen by the Registered Dietician in September. She stated Resident #167 was eating 51% to 75% for breakfast, 51% to 75% for lunch, and 75% to 100% for dinner. An interview with CNA R on 09/15/22 at 02:50 PM revealed she had noticed Resident #167's weight loss. She stated he appeared more exhausted, and his face was thinner. She stated Resident #167's intake varied. An interview with LVN U on 09/13/22 at 04:29 PM revealed Resident #167 appeared to have lost weight. He stated Resident #167' meal intake varied. He stated the resident ate up to 75% of his meals. He stated the resident's meal intake had reduced and he only ate 50% of his meal on 09/11/21. He stated the resident's meal intake was documented and information was shared in report to the nurse on the next shift. He stated nursing management entered the residents' weights into the EMR. He stated the DON notified the Registered Dietician if a resident had a weight loss. He stated he did not know Resident #167 had a severe weight loss. Record review of the facility's policy titled, Quarterly Nutritional Assessment and Progress Notes, dated 12/2020, reflected, The nutrition service manager, or designee will complete a quarterly nutritional assessment for residents to reflect current nutritional needs. Additional documentation of nutritional needs between quarterly assessments should be documented on the nutritional progress notes. Record review of the facility's policy titled, Assessment and Management of Resident Weights, dated 06/2020, reflected, To ensure each resident maintains acceptable parameters of weight and nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible based on the resident's comprehensive assessment. To ensure that a resident receives a therapeutic diet when there is a nutritional problem. Significant weight changes will be reviewed by the DNS or designated licensed nurse. Significant weight changes are: 5% in one month, 7.5% in three months, and 10% in six months.

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	455653	A. Building B. Wing	10/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Nursing Center	3326 Burgoyne Dallas, TX 75233

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42283 Based on interview and record review the facility failed to ensure each resident's drug regimens was free from unnecessary drugs used for excessive duration and without adequate indications for its use for one of five residents (Resident #35) reviewed for unnecessary medications. The facility failed to follow the physician's response regarding the pharmacy consultant's recommendation of reducing Resident #35's Fluoxetine 40 mg QD to Fluoxetine 20 mg QD. This failure could place residents at risk for possible adverse side effects, a decreased quality of life and continued use of possible unnecessary medications. Findings include: Record review of Resident #35's annual MDS Assessment, dated 07/15/22, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included: viral hepatitis, diabetes mellitus, hyperlipidemia, malnutrition, anxiety disorder, depression, bipolar disorder, asthma, cataracts, dysphagia, and primary insomnia. Record review of the monthly Pharmacy Drug Regimen Reviews dated 06/23/22, reflected the Pharmacist Consultant stated Resident #35 was receiving psychoactive medications that were due for review per CMS regulations. The Pharmacist Consultant stated Resident #35 needed to be evaluated for a trial dose reduction of Fluoxetine 40 mg QD to Fluoxetine 20 mg QD. Record review of the pharmacy note to the attending physician, dated 06/23/22, reflected in response to the recommendation made by the pharmacist about Resident #35's Fluoxetine 40 mg QD, the doctor disagreed to change the medication to Fluoxetine 20 mg QD. The physician's response stated Resident #35 had an active diagnosis [depressive disorder] continue with no GDR at this time. Record review of Resident #35's September 2022 Physician's Orders reflected she was prescribed Fluoxetine HCL Capsule 20 mg give one capsule by mouth in the morning related to major depressive disorder, recurrent severe without psychotic features on 07/07/22. Record review of Resident #35's September 2022 Physician's Orders reflected she did not have an order for Fluoxetine HCL Capsule 40 mg give one capsule by mouth in the morning related to major depressive disorder, recurrent severe without psychotic Record review of Resident #35's MAR, dated September 2022, revealed Resident #35 continued to receive Fluoxetine 20 mg QD after the physician did not agree with the resident's dose reduction. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 09/15/22 at 04:17 PM revealed she was not aware the physician did not agree with the pharmacist consultant's recommendation to reduce Resident #35's Fluoxetine 40 mg QD to Fluoxetine 20 mg QD. She stated Resident #35 received Fluoxetine 20 mg QD every morning since 07/07/22 and has not been affected by the dose reduction. She stated nursing management was responsible for ensuring physician recommendations were followed. She stated if the physician did not agree with the pharmacist consultant's recommendation, nursing should not have changed Resident #35's Fluoxetine 40 mg QD order. Record review of the facility's Medication-Drug Regimen Review Policy, dated 05/2017, reflected Procedure . 5.a.The Pharmacy Consultant drug regimen review and nursing medication documentation review reports are processed as follows: The report is provided by the Pharmacy consultant upon exit from the home; The physician provides a written response to the home after the report is sent; A copy of the report is kept by the home until the physicians' signed response is returned; The physicians' response is provided to the Pharmacy Consultant for review and then filed by the home; The home maintained copies of signed reports on file for at least two years.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on interview and record review, the facility failed to ensure residents who use antipsychotic drugs receive gradual dose reduction, and behavioral interventions, unless clinically necessary contraindicated, in an effort to discontinue these drugs for 1 of 4 residents (Residents #142) reviewed for unnecessary psychotropic meds. The facility administered an antipsychotic medication without adequate indications for use and did not obtain a rationale for continuing the concurrent use of the psychotropic for Residents #142. This failure could place any resident on psychoactive medications and those with a diagnosis of dementia administered with antipsychotic meds, at risk for receiving unnecessary drugs and adverse reactions. Findings included: Record review of Resident #142's clinical record revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of major depressive disorder, vascular dementia with behavior disturbances, delusions, impulse disorder, dysphagia, lack of coordination. Record review of Resident #142's quarterly MDS assessment, dated 8/17/22 revealed resident #142 had a BIMS score of 3 (cognitive skills for daily decision making severely impaired), rarely or never understood. Review of the active diagnosis reflected depression, psychotic disorder (other than schizophrenia) was checked. Record review of undated Resident #142's care plan revealed he had cognitive function/dementia or impaired thought process related to dementia. He required psychotropic medications (Seroquel) for the diagnosis of depression Review of the psychiatrist assessment report dated 09/01/22 reflected, pt is on hospice, this clinician has dc'd Seroquel more than once as there is no appropriate dx, and either hospice/PCP has returned it to active orders. This clinician dc'd pt from roster d/t facility not being open to other med interventions for agitation D/T pt's hospice status, will DC again and defer to hospice/PCP Record review of Resident #142's Physician's Orders dated 09/15/2022, revealed give Seroquel 50 mg tablet, 1 tablet by mouth two times a day related to other specified persistent mood disorders. Start dated 06/30/22. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/14/22 at 03:31 PM with the DON revealed the facility met monthly with the Psychiatrist and facility management. The DON stated she was not aware of the Psychiatrist Doctor's note, and if the Psych Dr indicated there should be an appropriate diagnosis for the medications, then the facility was to make sure the medication had the appropriate diagnosis. She stated medications prescribed should be containing the appropriate indication of the medication. She stated she had not seen any side effects but there is a potential for the medication to have side effects like dry mouth, weakness and vomiting. Review of the facility psychotherapeutic drug management, revised 06/20 reflected, .II. The facility will make every effort to comply with state and federal regulations related to the use of psychopharmacological medications in the long-term care facility to include regular review for continued need, appropriate dosage, side effects, risks and/or benefits IX. Psychiatrist/Mental health Responsibility (When available to the facility) A. Provide consultation services. B Assists the facility and the attending medical practitioner in establishing appropriate guidelines for use, dosage and monitoring pf psychotropic medications.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40316 Based on observation, interview, and record review, the facility failed to provide or obtain from an outside resource, routine dental services and emergency dental services to meet the needs of each resident for 4 of 8 residents (Residents #6, #61, #77 and #108) reviewed for dental services. 1. The facility failed to ensure Resident #6 received dental services for decaying teeth that needed to be extracted. 2. The facility failed to ensure Resident #61 received dental services for missing dentures. 3. The facility failed to ensure Resident #77 received dental services for decaying teeth. 4. The facility failed to ensure Resident #108 received dental services for a broken tooth. These failures could place residents at risk for infection and/or weight loss, and a decreased quality of life. Findings include: 1. Record review of Resident #77's, undated, face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included cerebral infarction (a result of disrupted blood flow to the brain), Type II diabetes (a condition in which the body doesn't produce enough insulin or resists insulin), epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), hypertension (high blood pressure), gastro-esophageal reflux disease (a digestive disease in which stomach acid or bile irritates the lining of the esophagus), and chronic kidney disease. Record review of Resident #77's Admission Assessment, dated 11/23/2021, revealed the resident had broken or carious teeth. Record review revealed Resident #77's name was not on the facility list of residents referred to Dental Services, as of the report date of 8/3/2022. Record review of Resident #77's electronic health record revealed a gradual weight loss of 12 pounds from November 2021 to September 2022. A diet order dated 6/28/22 for a regular diet, regular texture, thin consistency was noted . Observation on 9/13/22 at 2:35 p.m. revealed Resident #77 had missing top teeth. Observation and interview on 9/14/22 revealed Resident #77 smiled and indicated he had no top teeth except one. He indicated on the far back left he had decayed bottom teeth . Observation on 09/15/22 at 8:37 a.m. revealed Resident #77 had consumed 90% of the food on the breakfast tray sitting on his bedside table. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #77 on 9/13/22 at 2:21 p.m. revealed he would like to see a dentist. He said when he first arrived at the facility, he was told he would see a dentist but had not . He said he had no teeth, and it was hard for him to eat. 2. Record review of Resident #61's face sheet indicated Resident #61 was admitted on [DATE] with the diagnoses which included type 2 diabetes, insomnia (difficulty sleeping), low back pain, lack of coordination, muscle wasting, difficulty walking, unsteadiness on feet, generalized muscle weakness, softening of the bones, and enlarged prostate. In an interview with Resident #61 on 09/12/22 at 01:02 PM, Resident #61 said, he had dentures, and when he was going back and forth from the hospital, they went missing. Resident #61 stated they [the facility] wanted him to pay out of pocket for his dentures and he couldn't afford it. Resident stated that the facility lost his dentures and he felt they should take care of the costs. Record review of Resident #61's MDS quarterly assessment, completed on 8/02/22 by MDS J indicated no dental problems. Record review of Resident #61's care plan, dated 8/02/22, revealed no indication that dental problems had been identified. Record review of a list of residents scheduled for dental work, dated 8/03/22, revealed Resident #61 was not on the list . 3. Record review of Resident #108's face sheet indicated the resident was admitted to the facility on [DATE] with diagnoses which included: cerebral infarction (stroke), hyperlipidemia (high cholesterol), generalized muscle weakness, need for assistance with personal care, difficulty walking, muscle wasting and atrophy, unsteadiness on feet, lack of coordination, iron deficiency anemia (low iron in blood), vitamin B12 deficiency anemia (low B12 in blood), type 2 diabetes mellitus, bipolar disorder, major depressive disorder, generalized anxiety disorder, insomnia (difficulty sleeping), chronic pain, idiopathic peripheral autonomic neuropathy (nerve disease of hands and feet), congestive heart failure (heart disease), asthma, and right-sided hemiplegia (paralysis on right half of body). Record review of Resident #108's MDS quarterly assessment, completed on 8/11/22, by MDS K indicated no dental problems . Record review of Resident #108's care plan, dated 8/18/22, revealed no indication that dental problems had been identified. Record review of a list of residents scheduled for dental work, (dated 8/03/22,) revealed that Resident #108 was not on the list . In an interview on 09/12/22 at 12:50 PM, Resident #108 said she had a broken tooth. She brought it up at the Resident Council, but nothing was done about it . In an interview on 09/13/22 at 01:37 PM with the Social Worker revealed she was not aware of Resident #108's complaint of a broken tooth. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/14/22 at 02:40 PM with MDS K/MDS Coordinator revealed it was important to do an accurate MDS assessment because it captured an accurate picture of that resident at that point in time. MDS K said, if assessments were not accurate the care plan will would not be accurate. When asked if she was aware Resident #108 had a broken tooth, MDS K said, I'm not sure I'd have to look into it a little further. 4. Record review of Resident #6's face sheet revealed the resident was admitted on [DATE] with diagnoses which included type 2 diabetes mellitus with foot ulcer, anemia (low iron in blood), major depressive disorder, obstructive and reflux uropathy (disorder of urination), muscle wasting and atrophy, unsteadiness on feet, lack of coordination, anxiety disorder, peripheral vascular disease (disease of blood vessels in arms and legs), acquired absence of left leg below knee, vascular dementia without behavioral disturbance (type of dementia related to blood vessel disease), hepatitis C, muscle wasting and atrophy, hyperlipidemia (high cholesterol), paranoid schizophrenia, bipolar disorder, insomnia, hypertension (high blood pressure), atherosclerosis (narrowed arteries), gastro-esophageal reflux disease (acid reflux), and enlarged prostate. Record review of Resident #6's MDS quarterly assessment, completed on 6/09/22 by MDS K indicated no dental problems. Record review of Resident #6's care plan, dated 5/31/22, revealed no indication that dental problems had been identified. Record review of a list of residents scheduled for dental work, dated 8/03/22, revealed Resident #6 was not on the list . In an interview on 09/12/22 at 01:27 PM with Resident #6 revealed the resident had problems with his teeth and needed a couple of teeth pulled. Resident #6 stated he asked the nurse to see the dentist, and only saw him one time . In an interview on 09/13/22 at 01:37 PM with the Social Worker revealed she was not aware Resident #6 had teeth that needed to be pulled The Social Worker stated the protocol was if a resident had dental issues facility staff would either put a note under her door or bring up the problem to a nurse or herself. The Social Worker stated they sometimes they found out about these problems in the care plan meeting. The Social Worker stated if residents didn't get dental problems treated, their needs were not being met. Interview with the Social Worker and SW Assistant on 9/13/33 at 1:37 PM. revealed the Social Worker worked at the facility for 2 months and the SW Assistant worked at the facility for 3 months. The Social Worker said when she started at the facility she requested service lists, which included a dental service list. They both said they were not aware of any dental issues with Resident #77. The Social Worker said staff put notes under her door or spoke to her directly, and residents would come talk to her, and they worked on the issues that were brought to them. Social Worker said they had care plan meetings and concerns were brought up during these meeting. The Social Worker said if a resident did not receive basic services, their needs were not being met, and said dental issues would be a social service responsibility if they were made aware of it. The Social Worker said they didn't round on residents for dental needs, as they couldn't round on 200 people. The Social Worker said not receiving needed dental services could affect how a resident felt about themselves and could affect their eating. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 09/14/22 at 12:44 PM. with ADON H revealed she worked at the facility for about 3 months and was familiar with Resident #77. She said if she noticed something with a resident's teeth, she would report it to the doctor and the Social Worker, and said a dentist went to the facility routinely. ADON H said she had not noticed anything with Resident # 77's teeth, and she routinely observed he consumed 75-100% of his meal trays. In an interview on 09/15/22 at 09:00 AM with ADON L, revealed she identified residents who needed dental care because the nurse or resident would tell her, and she'd notify the doctor and Social Worker. ADON L said if a resident didn't receive dental care it could cause Sepsis, trouble eating/chewing, and it can cause them a lot of pain. ADON L stated she was not aware Residents #61, #108, and #6 needed dental care. Interview with the DON on 09/14/22 at 3:45 p.m. revealed the process to identify a resident for dental care services began with the admitting nurse, who looked for any dental issues. The admitting nurse then notified social services, and social services would order any needed ancillary services. The DON said potential problems with a resident not receiving dental care when indicated could be weight loss and/or malnourishment which could lead to other health issues, the inability to eat or enjoy food, and not being able to participate in activities that involved food. Interview with the Administrator on 09/15/22 at 1:30 p.m. revealed a resident had the right to receive dental care. He said it was the facility's responsibility to ensure a resident was provided dental care when needed. The Administrator said anybody could make a referral; nursing, and social services both made referrals, and social services was ultimately responsible. He said not receiving needed dental services could result in a resident's quality of life being diminished, not being able to eat and weight loss. Record review of the facility policy Referrals to Outside Services, dated 08/2020, revealed The Director of Social Services coordinates the referral of residents to outside agencies/programs to fulfill resident needs for services not offered by the Facility. The Director of Social Services is responsible for locating agencies and programs that meet the needs of residents, facilitating the execution of service provider contracts, and referring residents to existing contracted providers . 45333

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observation, interview and record review the facility failed to, in accordance with accepted professional standards and practices, maintain medical records on each resident that were complete and accurately documented for one (Resident #86) of 11 residents reviewed for medical records. 1. The facility failed to ensure Resident #86's face sheet, Wound Care Nurse Progress Notes and Physician Orders were updated to indicate he had MRSA (Methicillin Resistant Staphylococcus Aureus- anti-biotic drug resistant bacterial staph infection) and Enterococcus Faecalis- (anti-biotic drug resistant bacterial gastrointestinal tract infection). 2. The facility's nurses failed to document in the nurses notes on 09/02/22, why Resident #86 needed contact isolation. 3. The facility nurses failed to completely review and document Resident #86's Lab results on 09/04/22 and were unaware Resident #86 had Enterococcusus Faecalis diagnosis (Gastrointestinal bacterial infection). 4. The facility's nurses failed to document in the nurses notes about Resident #86's MRSA and Enterococcus Faecalis from 09/04/22 to 09/15/22. These failures could place residents at risk of inadequate care and treatment which could result in acute illnesses, distress, decreased psycho-social well- being and quality of life. Findings include: Record review of Resident #86's face sheet, printed on 09/14/22, revealed a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included Muscle Wasting, Difficulty Walking, Unsteadiness on feet, Other lack of coordination, Neuropathy (nerve damage), Depressive Episodes (mood disorder), Hypertension (high blood pressure). Record review of Resident #86's Annual MDS assessment, dated 07/12/22, revealed a BIMS (scale 0-15) score 13 (cognitively intact), ADL (bed mobility, transfer, dressing, toileting, personal hygiene), supervision with one person assistance, not able to walk, needs staff assistance with moving on and off toilet and surface to surface transfer, use of a wheelchair, occasionally incontinent and at risk of developing pressure ulcers/injuries. Record review of Resident #86's Order Summary Report printed 09/14/22, revealed on 09/02/22 Contact Isolation every shift for infection control for 11 days .Bactrim DS Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim) give 1 tablet by mouth every 12 hours for infection to right foot for 10 days. Record review of Resident #86's Care Plan printed 09/14/22, revealed Diabetes Mellitus, skin impairment, communication problem, refuses showers, Diabetic Ulcer Right 2nd toe, Antibiotic therapy of Bactrim related to wound infection on foot, contact isolation related to MRSA infection to the wound of right foot and required ADL assistance. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #86's Weekly Skin Assessment, dated 09/08/22, by ADON A revealed resident had Skin impairment, areas of impairment: Other - right foot; see chart. Record review of Resident #86's Weekly Wound Progress Notes, dated 09/08/22, by LVN C, revealed the resident had two wounds, infection right dorsal foot wound bed was 20% S and 80% G tissue seen and size of wound (0.8x1x.0.4) and diabetic right 2nd toe wound bed 100% N tissue seen and size of wound (0.5x0. 3x0.1) .wound care nurse performed rounds with MD. Orders noted and processed. Record review of Resident #86's Doctor Order Summary Report, dated 09/14/22, revealed on 09/02/22, Contact Isolation Order for MRSA added to diagnoses listing. Record review of Resident #86's Nurse Progress Notes, printed 09/14/22, revealed on 09/02/22 by LVN D, Lab results received, Resident placed on contact isolation. NP P notified of results, and he asked to wait for sensitivity results. Record review of Resident #86's Nurse Progress Notes, on 09/04/22, by LVN E, revealed Lab results sent to NP with new orders to start Bactrim DS Q 12h x 10 days. Family member contacted and resident aware of new order. Record review of Resident #86's Nurse Progress Notes, printed 09/14/22, revealed from 09/04/22 to 09/15/22 documentation for Anti-biotic treatment with Bactrim DS for right foot infection.(There was no documentation about the resident's MRSA, Enterococcus Faecalis or contact isolation precautions documented in the nurses' notes). Record review of Resident #86's Final Lab Results Report, dated 09/05/22, revealed Culture Result: Isolate: Heavy growth of Methicillin Resistant Staphylococcus Aureus (MRSA) isolated .Isolate: Moderate Growth Enterococcus Faecalis isolated Observation on 09/13/22 at 11:34 AM, revealed a contact isolation bin outside the room door and Resident #64 had the B bed and the only way to get to it was to pass by Resident #86, his bed and [NAME] drawer. Observation on 09/13/22 at 11:36 AM, revealed an isolation bin outside the room door and Resident #86 had the A bed and he was sitting in his wheelchair with his TV on, there was no bedside commode and there were yellow and red biohazard boxes in the bathroom. Interview on 09/13/22 at 10:40 AM, the DON stated Resident #86 has been on contact isolation since 09/02/22, for MRSA of a foot wound that was covered and contained at all times and do to come off of contact isolation on 9/15/22. Interview on 09/13/22 at 8:45 AM, the ADON B stated Resident #86 was on contact isolation for a wound that was covered with a dressing and took Bactrim DS for a right foot infection and his roommate Resident #64 was not taking antibiotics and would have to check the medical records to be sure. Interview on 09/14/22 at 2:44 PM, LVN F stated the Resident's new diagnoses was put in into Resident #86's Medical Records by the MDS nurse. (continued on next page)

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	455653	A. Building B. Wing	10/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Nursing Center	3326 Burgoyne Dallas, TX 75233

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/15/22 at 9:47 AM, LVN D stated Resident #86 was put on contact isolation on 09/02/22, the ADON A called him that night about the lab results for Resident #86 and reviewed the lab results, contacted the NP P, and was told by NP P to place Resident #86 on contact isolation, as a precaution for the suspected MRSA of his lab result and the NP P said to wait for the culture result. LVN D stated he was unaware of Resident #86's Enterococcusus Faecalis diagnosis. Interview on 09/15/22 10:34 AM, LVN E stated Resident #86 was put on contact isolation for his wound infection of his right foot for the MRSA on 09/04/22 and was not sure about the Enterococcusus Faecalis. She stated she received Resident #86's wound culture report result which showed he had a foot infection then she told ADON A about his change in condition and updated his doctor and family about his diagnosis. Interview on 09/15/22 at 11:27 AM, ADON A stated they received the labs for Resident #86, and he was put on contact isolation for MRSA then NP P, family were notified, and the DON and Admin discussed Resident #86's new diagnoses in the clinical meeting for MDS to add the new diagnoses into the EMR. ADON A stated she was unaware Resident #86 had a diagnosis Enterococcusus Faecalis and was not sure how that was missed. Interview on 09/15/22 at 12:06 PM, ADON B stated Resident #86's labs revealed a diagnosis of heavy growth of MRSA and moderate growth of Enterococcusus Faecalis and she had just started working at the facility and did not know the policies for contact isolation yet. She stated in nursing school she was told if a resident was in a hospital setting with MRSA, they would automatically put a patient in contact isolation, but at this facility a resident with MRSA was put on contact isolation based on a doctor's order. She stated after review of Resident #86's Medical Records, she did not see MRSA or Enterococcusus Faecalis on his face sheet and nurses notes and was not sure why these diagnoses were not included on them. She stated the MDS coordinator was responsible for adding new diagnosis to the resident's records and if not added could cause problems with being able to properly care for the resident. Interview on 09/15/22 at 12:36 PM, MDS G stated he was responsible for putting the new diagnoses into the resident's records and had reviewed Resident #86's medical records during the care plan meeting and saw the MRSA diagnosis and updated his care plan for MRSA of right foot on 09/12/22. He stated normally he would put the new diagnosed information in the resident's record but got occupied and sidetrack with something else during the care plan meeting. He stated he was not aware Resident #86 had Enterococcus Faecalis diagnosis. He stated accurate records ensured that the resident was properly taken care of. Interview on 09/15/22 at 2:22 PM, the DON stated the MDS nurses were responsible for adding residents' new diagnoses from the nurses and that information was communicated in the morning meetings. She stated her expectation was for medications and diagnoses to be added correctly to the resident's medical records within 24 hours. She stated when it was confirmed Resident #86 had MRSA, the nurses should have started documenting in his nurses notes the specific infection they were treating the resident for. She stated since this had been brought to her attention, she planned to talk to the nurses about documenting what type of infections the resident was diagnosed with, to be more specific in documenting and to ensure MDS nurses carried over the resident's diagnoses to the diagnoses tab. She stated she was not aware Resident #86 had Enterococcus Faecalis. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/15/22 3:10 PM, the Admin stated he was not aware the nurses were not documenting Resident #86 MRSA infection into his records and added the MDS nurses were responsible for adding the residents diagnoses accurately. He stated once the nursing department notified the MDS nurse the MDS nurses were responsible for entering the resident's diagnoses into the system. He stated the timeframe for adding new diagnoses should be completed within 24 hours and stated he was not aware Resident #86 had Enterococcus Faecalis and not sure how the nurses missed that diagnosis and would talk to the nursing staff about reviewing the residents' records more thoroughly and said his expectations was for medical records to be accurate, accessible and secure. Record review of the facility's, undated, General Provisions: Medical Records Manual revealed, Purpose: To ensure the accurate documentation and maintenance of medical records by the facility .Policy: Clinical records, paper or electronic, will be kept for each resident admitted for care. Content will be in compliance with licensing and certifying governmental agency requirement and professional standards .Procedure: II. Records will be reviewed periodically for currency and completion Record review of the facility's Documentation-Nursing Policy, dated 06/2020, revealed Purpose: To provide documentation of resident status and care given by nursing staff .Policy: Nursing documentation will be concise, clear, pertinent, accurate and evidence based .Procedure: E. All laboratory data will be dated, timed and initialed when received and initially reviewed by a licensed .The date, time and signature of licensed nurse reviewing the laboratory data and disposition of that information shall be notated in the nurses' notes.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 37193 Based on observation, interview and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 24 residents (Residents # 523, #86 and #64) and 1 of 8 halls (100 hall) reviewed for infection control. 1. The facility failed to ensure CNA O performed hand hygiene while performing incontinent care for Resident #523. 2. The facility failed to follow their infection control policy for Transmission Based Precautions, because the Infection Preventionist did not access various risks associated with other resident placement options (cohorting); the bed B Resident #64 was not moved out of a room shared with bed A Resident #86, who required contact isolation for MRSA. 3. The facility failed to determine if Resident #64 was suitable to cohort with Resident #86 and did not conduct any labs and cultures to identify if he also had MRSA or other contagious infections. 4. The facility failed to ensure CNA N properly doffed Personal Protective Equipment (PPE) before exiting each room, while providing care to residents in isolation on the 100 hall. These failures could place residents at-risk of cross contamination of a highly infectious disease, which could result in a psycho-social decline or serious illness. Findings include: 1. Record review of Resident #523's face sheet, dated 09/15/22, revealed the resident was admitted to the facility on [DATE] with diagnoses which included disturbance psychosis, anxiety, major depressive disorder, respiratory disorder, hemiplegia and hemiparesis, difficult in walking and muscle wasting and atrophy. Record review of Resident #523's annual MDS, dated [DATE], revealed Resident #523's BIMS score was 6, which signified Resident #523 was moderately impaired. Required extensive to total assistance with activities of daily living. She was frequently incontinent of urine and always incontinent of bowels. Record review of Resident #523 care plan dated 9/15/22 reflected she had bladder incontinence related to dementia, impaired mobility. Goal was for Resident #523 to remain free from skin breakdown due to incontinence and brief use. Intervention was to check the resident frequently and as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN after incontinence episodes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/13/22 at 01:48 PM revealed CNA O provided care to Resident #523. CNA O positioned the resident and explained to the resident she was going to complete incontinent care. CNA O then gathered the resident supplies and provided the resident with privacy. CNA O completed hand hygiene and donned gloves. Unfastened the resident's brief and cleaned the residents front peri area with wipes, front to back. CNA O positioned the resident on her side and cleaned the resident's bottom area, the resident had a small bowel movement, and the brief was moderately soiled with urine and CNA O stated, seems the resident is still trying to go. CNA O proceeded to clean the resident, then removed the dirty brief. With the same gloves she used to clean the resident, CNA O applied the clean brief on the resident, fastened the brief. CNA O then removed the trash that was on the resident's bed then with the same gloves she straightened the resident's gown and covered the resident. CNA O proceeded to the toilet to clean her hands. In an interview on 09/13/22 at 02:05 PM with CNA O, she stated she was an agency staff. She stated she did not complete hand hygiene between care, because she forgot. CNA O stated sometimes she would wash her hands in between care. CNA O stated she was supposed to complete hand hygiene between care to prevent cross contamination. She stated after cleaning the resident the gloves could be soiled with feces and urine and when touching the clean brief and linens they would be contaminated. She stated she had not had any infection control training in the facility or with her agency, but she had attended an infection in-service in another facility about 3-4 months ago. In an interview on 09/14/22 at 03:33 PM with the DON revealed she hadn't completed any training or in-service on infection or incontinent care with CNA O. The DON stated CNA O was supposed to complete hand hygiene and change glove before care, and after cleaning the resident complete hand hygiene and apply clean gloves before applying the clean brief. Hand hygiene was required to prevent cross contamination that could cause infection. Record review of the facility policy titled incontinent care/perineal care with or without a catheter, dated 05/17, reflected .3. If resident is heavily soiled with feces, turn resident on side and clean away feces with tissue, wipes or incontinent brief. Discard soiled gloves along with the soiled brief and/or wipes. Cover resident, provide safety measures and wash hands with soap and water. 2. Record review of Resident #86's face sheet, printed on 09/14/22, revealed a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included Muscle Wasting, Difficulty Walking, Unsteadiness on feet, Other lack of coordination, Neuropathy (nerve damage), Depressive Episodes (mood disorder), Hypertension (high blood pressure). Record review of Resident #86's Annual MDS assessment, dated 07/12/22, revealed a BIMS (scale 0-15) score 13 (cognitively intact), ADL (bed mobility, transfer, dressing, toileting, personal hygiene), supervision with one person assistance, not able to walk, needs staff assistance with moving on and off toilet and surface to surface transfer, use of a wheelchair, occasionally incontinent and at risk of developing pressure ulcers/injuries. Record review of Resident #86's Order Summary Report printed 09/14/22, revealed on 09/02/22 Contact Isolation every shift for infection control for 11 days .Bactrim DS Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim) give 1 tablet by mouth every 12 hours for infection to right foot for 10 days. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #86's Care Plan printed 09/14/22, revealed Diabetes Mellitus, skin impairment, communication problem, refuses showers, Diabetic Ulcer Right 2nd toe, Antibiotic therapy of Bactrim related to wound infection on foot, contact isolation related to MRSA infection to the wound of right foot and required ADL assistance. Record review of Resident #86's Weekly Skin Assessment, dated 09/08/22, by ADON A revealed resident had Skin impairment, areas of impairment: Other - right foot; see chart. Record review of Resident #86's Weekly Wound Progress Notes, dated 09/08/22, by LVN C, revealed the resident had two wounds, infection right dorsal foot wound bed was 20% S and 80% G tissue seen and size of wound (0.8x1x.0.4) and diabetic right 2nd toe wound bed 100% N tissue seen and size of wound (0.5x0. 3x0.1) .wound care nurse performed rounds with MD. Orders noted and processed. Record review of Resident #86's Doctor Order Summary Report, dated 09/14/22, revealed on 09/02/22, Contact Isolation Order for MRSA added to diagnoses listing. Record review of Resident #86's Nurse Progress Notes, printed 09/14/22, revealed on 09/02/22 by LVN D, Lab results received, Resident placed on contact isolation. NP P notified of results, and he asked to wait for sensitivity results. Record review of Resident #86's Nurse Progress Notes, on 09/04/22, by LVN E, revealed Lab results sent to NP with new orders to start Bactrim DS Q 12h x 10 days. Family member contacted and resident aware of new order. Record review of Resident #86's Nurse Progress Notes, printed 09/14/22, revealed from 09/04/22 to 09/15/22 documentation for Anti-biotic treatment with Bactrim DS for right foot infection. Record review of Resident #86's Final Lab Results Report, dated 09/05/22, revealed Culture Result: Isolate: Heavy growth of Methicillin Resistant Staphylococcus Aureus (MRSA) isolated .Isolate: Moderate Growth Enterococcus Faecalis isolated 3. Record review of Resident #64's face sheet, dated 09/14/22, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #64 had diagnoses which included Vitamin B-12 deficiency, DMII (Diabetes), Hyperlipidemia (Abnormal high fat level in blood), Unspecified Dementia (Cognitive loss), Major Depression (mood disorder), Anxiety Disorder (Mental Illness), Metabolic Encephalopathy (Cognitive impairment). Record review of Resident #64's Quarterly MDS assessment, dated 07/16/22, revealed a BIMS (scale 0-15) score of 10, which indicated Moderate impairment, ADL extensive assistance two-person assistance for bed mobility, transfer, toileting, and personal hygiene, no steady able to stabilize with staff assistance, wheelchair use, catheter, ostomy and no skin conditions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #64's care plan, printed 09/14/22, revealed Impaired cognitive function/dementia-monitor, document, document change in cognition, indwelling catheter - monitor, report to doctor for signs of urinary tract infection, pressure ulcer development r/t immobility - notify nurse immediately of any new areas skin breakdown, diabetes, infection of the penile - monitor, document, report to doctor signs/symptoms of penial area, ADL - staff assist to toilet, bathing, dressing, eating, limited physical mobility: right side hemiparesis - monitor, document, report to doctor signs/symptoms of immobility, contractures Record review of Resident #64's Medication Administration Record, dated 09/14/22, revealed Cipro tablet 500 MG (Ciprofloxacin HCl) Give 1 tablet by mouth two times a day for penile discharge for 7 days [order date:09/05/22]. Record review of Resident #64's Nurses Note, by LVN E, dated 09/05/22, revealed Nurse observed discharge and redness on resident's penis. Catheter care provided by nurse. NP informed of new findings to start Cipro mg bid x 7 days and change foley to 18 fr. Foley changed; resident tolerated well. Family member called voicemail left. Record review of Resident #64's Nurses Note, by LVN Q, dated 09/13/22, revealed Resident continues on abt tx Cipro for penile discharge. Record review of Resident #64's Lab records did not reveal any labs for the past two months. Interview on 09/13/22 at 10:40 AM, the DON stated Resident #86 was on contact isolation for MRSA of a foot wound that was covered and contained at all times. She stated she reached out to corporate for support and worked at other facilities and as long as a wound was contained there was no problem with cross contamination. The DON stated she would have to look at the policy because they were vague. She stated Resident #86 had been on contact isolation since 09/04/22 and due to come off on 9/15/22, Resident #64 was getting antibiotic medication and treatment for a penile drainage related to his catheter and he had no recent labs/cultures to determine the cause of his infection or if he had MRSA because Resident #64's doctor had not ordered it. She stated there was no cross-contamination issues with Residents #64 and #86 sharing a room together, because they did not share the same bathroom and Resident #64 was bedbound and Resident #86 was up and about in his wheelchair, but always on his side of the room. She stated Resident #64 was not moved because they did not have any available rooms. Interview on 09/13/22 at 8:45 AM, the ADON B stated Resident #86 was on contact isolation for a wound that was covered with a dressing and took Bactrim DS for a right foot infection and his roommate, Resident #64, was on an antibiotic cipro for a penile discharge and required total care assistance for his care needs. She stated Resident #86 had been on contact isolation since 09/04/22 with antibiotic treatment for MRSA of the foot and for moderate growth of Enterococcusus faecalis (Gastrointestinal infection). She stated normally a resident with MRSA (Staph Infection) was placed in a room by themselves and not sure why Resident #86 was not moved out of the room. She stated she was still learning the policies because she had just started working at this facility. Observation on 09/13/22 at 11:34 AM, revealed Resident #64 had the B bed and the only way to get to it was to pass by Resident #86, his bed and [NAME] drawer. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/13/22 at 11:36 AM, revealed Resident #86 had the A bed and was sitting in his wheelchair with his TV on, there was no bedside commode and there were yellow and red biohazard boxes in the bathroom. Interview on 09/14/22 at 2:44 PM, LVN F stated Resident #64 had no infectious disease, but was taking an antibiotic for a penis drainage and was not on contact isolation but his roommate, Resident #86, was on contact isolation for a foot infection. She stated it would be better to separate a resident from a roommate with MRSA to prevent cross contamination. Interview on 09/15/22 at 8:51 AM, the Housekeeping Director stated MRSA was a staph infection that was a contagious infection in the wound or in the body and unless both residents had MRSA the resident without MRSA should be separated from the resident with MRSA. Resident #86, the A-bed, resident had MRSA of his foot and was on contact isolation but was not sure why Resident #64 was in a contact isolation room because he did not have MRSA. Interview on 09/15/22 at 9:47 AM, LVN D stated Resident #86 was put on contact isolation on 09/02/22, ADON A called her that night about the lab results for Resident #86 and reviewed the lab results, contacted the NP and was told to place Resident #86 on contact isolation, as a precaution for the suspected MRSA on his lab result and NP P said to wait for the culture result. LVN D stated he was unaware of Resident #86's Enterococcusus Faecalis diagnosis. He stated a bacterial infection could spread by contact to another resident and with contact isolation a person had to use PPE and practice good hand hygiene and to alert everyone because anything touched in the room could pose an infection risk. He stated if the roommate did not have MRSA, he should be moved out of the room but if the roommate had MRSA also, they could remain in the room, because it was not safe or advised for both residents to be in the same room if one had MRSA, in order to prevent contact and infection of the other resident. Interview on 09/15/22 10:34 AM, LVN E stated Resident #86 was put on contact isolation for his wound infection of his right foot for the MRSA and was not sure about the Enterococcusus Faecalis. She stated she received Resident #86's wound culture report results on 09/04/22 which showed he had a foot infection then she told ADON A about his change in condition and updated his doctor and family about his MRSA diagnosis. She stated MRSA was Methicillin Staphylococci Resistant Aureus was a contagious infection which required the resident to be on contact isolation and if someone provided care to a resident with MRSA, the infection could be transferred to the other residents. She stated Resident #64 had no wound or MRSA and did not use the bathroom, because he did not get up and was bed bound and peri-wipes were used to do incontinent care. Interview on 09/15/22 at 11:27 AM, ADON A stated they received the lab results for Resident #86, and he was put on contact isolation for MRSA then NP P and family were notified. ADON A stated she was unaware Resident #86 had a diagnosis Enterococcusus Faecalis and was not sure how that was missed. Interview on 09/15/22 at 11:00 AM, CNA I stated she was not sure why Resident #86 was in the same room with Resident #64. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/15/22 at 11:27 AM, ADON A stated MRSA was spread by touch, which required contact isolation. Resident #86 received a lab result which showed he had MRSA and was put on contact isolation related to his foot wound. She stated she knew Resident #86 had MRSA but was not aware of the Enterococcusus faecalis diagnosis. She stated in nursing practice it was okay to cohort if the resident was not sharing the same space even though the two residents shared the same room. Interview on 09/15/22 at 12:06 PM, ADON B stated Resident #86's lab results revealed a diagnosis of heavy growth of MRSA and moderate growth of Enterococcusus Faecalis and said she had just started working at the facility and did not know the policies for contact isolation yet. She stated in nursing school she was told if a resident was in a hospital setting with MRSA, they would automatically put a patient in contact isolation, but at this facility a resident with MRSA was put on contact isolation based on a doctor's order for it. Interview on 09/14/22 at 3:10 pm, the Admin stated his expectation to prevent the spread of MRSA was to make sure the staff followed all of the infection control protocols, he stated the staff had an infection control training today on hand hygiene and incontinent care. He stated he was not aware Resident #86 had Enterococcus Faecalis and was not sure how the nurses missed that information. Record review of the facility's Infection Prevention and Control Program Policy date revised 06/2020 revealed, Purpose: The [SIC]ensure the facility establishes and maintains an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with federal and state requirements Record review of the facility's Resident Isolation - Categories of Transmission Based Precautions policy, dated 06/2020, revealed, Purpose: To ensure that transmission-based precautions are used when caring for residents with communicable diseases or transmittable infections .Resident care equipment, when possible, the use of non-critical resident care equipment items such as a .bedside commode .is dedicated to a single resident (or cohort of residents) .Contact Precautions: A. Contact precautions are implemented for residents known or suspected to be infection or colonized with microorganisms that are transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. Examples of infections requiring contact precautions include but are not limited to: Gastrointestinal, skin, wound infections, or colonization with multi drug resistant organism (MRSA) B. Resident Placement ii. When private room is not available, the infection preventionist assesses various risks associated with other resident placement options (cohorting) Record review of the facility's Documentation-Nursing Policy dated 06/2020 revealed, Purpose: To provide documentation of resident status and care given by nursing staff .Policy: Nursing documentation will be concise, clear, pertinent, accurate and evidence based .Procedure: E. All laboratory data will be dated, timed and initialed when received and initially reviewed by a licensed .The date, time and signature of licensed nurse reviewing the laboratory data and disposition of that information shall be notated in the nurses' notes 4. Observation of Hall 100 on 09/12/2022 at 12:00 PM revealed 5 out of the 16 rooms on the hall were isolation rooms. There were 2 trash bins observed in the hallway near two of the isolation rooms. CNA N was observed walking down the hallway dressed in full PPE, which included a N95 mask, face shield, gown, and gloves. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Nursing Center	3326 Burgoyne Dallas, TX 75233

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with CNA N on 09/12/2022 at 12:08 PM revealed she had been employed at the facility for about two weeks. CNA N stated she was assigned to work on the 100 hall, which included the isolation rooms. CNA N stated she was providing care in an isolation room and was going to the shower room to doff her PPE. CNA N stated she had always doffed in the shower room and had not been told not to do so. CNA N stated she had received training on infection control upon being hired. She stated that she was trained to doff before exiting each isolation room to prevent the possibility of cross-contamination; however, there was not a place to doff in each room so all staff would normally go to the shower room. Interview with the DON on 09/12/2022 at 12:15 PM revealed all staff had been trained and in-serviced on infection control protocols and knew to doff PPE in the trash bins located outside of the isolation rooms. The DON stated the trash bins should have been located at the door inside of each isolation room to prevent staff from exiting the rooms with PPE still on. The DON stated the risk of staff not properly doffing PPE was cross-contamination and the spread of infection as there were other residents residing on the 100 hall who were not on isolation. Record review of the facility's policy titled Infection Prevention and Control Program, revised 06/2020, reflected in part the following: Infection Control Policies and Procedures: A. The facility's infection control policies and procedures are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. -Establish guidelines for implementing isolation precautions, including standard and transmission-based precautions.