STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675905	A. Building B. Wing	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood of Grapevine	1500 Autumn Drive Grapevine, TX 76051

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44006 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as is possible and that each resident received adequate supervision to prevent accidents for 5 of 5 residents (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) reviewed for accidents and supervision. 1. The facility failed to ensure Resident #1, who resided in the memory care unit, was provided a hazard free environment with adequate supervision when Resident #1 ingested body wash on 02/07/23, which was found while wandering in the room of Resident #2 and Resident #3. 2. The facility failed to provide a hazardous free environment in the memory care unit, even after Resident #1 ingested body wash on 02/07/23, when bottles of body wash and body lotion were left out in the room of Residents #4 and #5 on 02/15/23. These failures put memory care residents at risk of serious injury, hospitalization , or even death. An Immediate Jeopardy situation was identified on 02/15/23 at 3:54 PM. The Immediate Jeopardy was removed on 02/16/23 at 2:50 PM. The facility remained out of compliance at a scope of pattern and a severity of potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems. Findings Included: Resident #1 Record review of Resident #1's electronic Facesheet, dated 02/15/23, revealed Resident #1 was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #1's diagnoses included senile degeneration of brain (the mental deterioration and loss of intellectual ability), neurocognitive disorder with Lewy bodies (affect chemicals in the brain whose changes, can lead to problems with thinking, movement, behavior, and mood), and schizoaffective disorder bipolar type. Record review of Resident #1's Quarterly MDS assessment, dated 01/21/23, revealed Resident #1's BIMS score was 00 which indicated severe cognitive impairment. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's care plan, initiated on 11/07/22, reflected Resident #1 had a communication problem due to dementia and the interventions included Ensure/provide a safe environment . avoid isolation. Further review revealed Resident #1 had behavior potentially causing harm, due to dementia, as evidenced by ingested non-food substance and the interventions included if wandering or pacing, initiate visual supervision during acute episode . staff will keep all potential non-food items out of view or accessibility. A record review of Resident #1's Progress Notes, dated 02/07/23, revealed LVN A documented Upon passing medication this am, resident was noted to be walking down hallway with red container in hand, this writer seen resident put container to mouth, resident was able to take one drink from container before I approached her. I noted that the container was a bottle of liquid hand soap from another resident's room. Assessed resident's oral cavity and rinsed mouth out. NP made aware, new order to monitor and obtain CBC, BMP. Poison control notified. Spoke with RN, stated push water as possible, monitor tolerance of water. Call back if further assistance needed. Case #75473317. RP, DON, Administrator Aware. Resident #2 Record review of Resident #2's electronic Facesheet, dated 02/15/23, revealed Resident #2 was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #2's diagnoses included unspecified dementia with behavioral disturbance (impaired ability to remember, think, or make decisions that interferes with doing everyday activities., agitation, anxiety, and psychosis), bipolar disorder (mental health condition that causes extreme mood swings that include emotional highs), wandering in disease classified elsewhere, and cognitive communication deficit. Record review of Resident #2's Quarterly MDS assessment, dated 01/12/23, revealed Resident #2's BIMS score was 5 which indicated severe cognitive impairment. Record review of Resident #2's care plan, initiated on 01/24/23, reflected Resident #2 had communication problem due to dementia with interventions that included Ensure/provide a safe environment. Further review revealed Resident #2 had complication due to impaired cognitive function/dementia and the interventions included cue, reorient, and supervise as needed. Record review of Resident #2's Progress Notes, dated 02/07/22, revealed Communication with Family this nurse spoke with RP and asked him not to bring anything such as soaps, colognes, spray bottles, any sort of chemicals. If there are any question regarding this to contact me. Cell phone number provided. Verbalized an understanding. Resident #3 Record review of Resident #3's electronic Facesheet, dated 02/15/23, revealed Resident #3 was an [AGE] year-old male who admitted to the facility on [DATE]. Resident #3's diagnosis included unspecified dementia, unspecified severity, without behavioral disturbance (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems). Record review of Resident #3's Quarterly MDS assessment, dated 12/14/23, revealed Resident #3's BIMS score was 3 which indicated severe cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #3's care plan, initiated on 01/24/23, reflected Resident #3 had risk for complications due to impaired cognitive dementia or impaired though process with the interventions included monitor to MD any changes in cognitive function, specifically changes in decision making ability. Resident #4 Record review of Resident #4's electronic Facesheet, dated 02/15/23, revealed Resident #4 was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #4's diagnoses included unspecified dementia with behavioral disturbance (impaired ability to remember, think, or make decisions that interferes with doing everyday activities., agitation, anxiety, and psychosis), schizoaffective & bipolar disorder (mental health condition that causes extreme mood swings that include emotional highs), and restlessness and agitation. Record review of Resident #4's Comprehensive MDS assessment, dated 12/23/22, revealed Resident #4's BIMS score was 99 which indicated the resident was unable to complete the interview. Record review of Resident #4's care plan, initiated on 01/04/23, reflected Resident #4 was at risk for wandering with interventions that included identify pattern of wandering and was a resident looking for something. Resident #5 Record review of Resident #5's electronic Facesheet, dated 02/15/23, revealed Resident #5 was an [AGE] year-old female who admitted to the facility on [DATE]. Resident #5's diagnoses included unspecified dementia without behavioral disturbance (impaired ability to remember, think, or make decisions that interferes with doing everyday activities., agitation, anxiety, and psychosis) and Alzheimer's disease. Record review of Resident #5's Comprehensive MDS assessment, dated 02/03/23, revealed Resident #5's BIMS score was 0 which indicated severe cognitive impairment. Record review of Resident #5's care plan, initiated on 01/28/23, reflected Resident #5 had risk for complications due to impaired cognitive dementia or impaired though process with the interventions included monitor to MD any changes in cognitive function, specifically changes in decision making ability. In an interview on 02/15/23 at 9:45 AM, the ADMN stated LVN A noticed Resident #1 putting a red container to her mouth and immediately went to the resident and took the bottle. The ADMN stated it was a liquid soap bottle from Bath & Body works. She stated LVN A contacted poison control and was told to provide lots of water and monitor for change in condition. The ADMN stated LVN A was taking vitals and monitoring resident during mealtimes. She stated Resident #1 did not have a change in condition. The ADMN stated the liquid soap should not have been in a resident's room in memory care. She stated they did a sweep in memory care and removed any items that would have been harmful. The ADMN stated the nurses' completed weekly sweeps. She stated she in-serviced staff on abuse/neglect, chemicals, and prohibited items in memory care. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An initial observation of the Memory Care Unit on 02/15/23 at 9:59 AM, revealed majority of the residents in the center dining area of the unit. There were two residents walking up and down the hall. Some of the resident's doors were open in the unit and there were not residents in the rooms. An observation on 02/15/23 at 10:01 AM revealed the door to Resident #4 and Resident #5's room, was open and bottles of body wash and body lotion were left out on the sink. The bottles had liquid in them. The bottle of body wash was observed to have the cap flipped up and ready to pour. Resident #4 was observed in her bed asleep, and Resident #5 was not in the room. An interview was attempted with Resident #1 on 02/15/23 at 10:03 AM. Resident #1 was not verbally responding to the questions being asked, nor was she responding non-verbally by gesturing with her head or hands to yes and no questions. An observation on 02/15/23 revealed Resident #1's room was on the hall near the entrance of the Memory Care Unit. Residents #4 and #5's room (#310) was located on a different hall from Resident #1 towards the beginning of the hall entrance. Residents #2 and #3's room (#327) was located on a different hall than Resident #1's and was at the very end of the hall next to the emergency exit door. In an interview on 02/15/23 at 10:25 AM, the DON stated she removed the bottles of body wash and body lotion from the room of Residents #4 and #5. She stated the CNAs must have left it out when they got Residents #4 and #5 up for the day. The DON stated the body wash and body lotion should not have been left out because one of the residents could have got them, which could be harmful. She stated those items were supposed to be in the shower room, which was secured. In an interview on 02/15/23 at 10:35 AM, LVN A stated on 02/07/23 she was in the hallway passing meds and saw Resident #1 with a red bottle. LVN A stated she immediately started walking towards Resident #1 and saw her put the bottle up to her mouth and drink from the bottle. LVN A stated it was a bottle of body wash from Bath & Body Works and had Resident #2's name on it. She stated Resident #1 must have wandered into Residents #2 and #3's room and picked it up. She stated she took the bottle away from Resident #1 and had her open her mouth. LVN A stated there was soap residue on her tongue, so she knew she ingested the body wash. She stated the bottle was not empty and she did not know how much Resident #1 ingested. LVN A stated she knew the soap had chemicals that should not be ingested, so she contacted poison control and the facility's physician. She stated both poison control and the physician told her to give Resident #1 lots of water, monitor her for change in conditions, or if she was to become lethargic, then to send Resident #1 out to the hospital. LVN A stated she took Resident #1's vitals every 1-2 hours and vitals were good. She stated she had Resident #1 drink about 4-5 large cups of water and monitored her during lunch. LVN A stated Resident #1 ate her lunch well and seemed like her normal self. LVN A stated Resident #1 was known to walk around and go into other resident's rooms and take things. She stated Resident #1 was known to pick things up and ingest them. LVN A stated there was a time she picked up a bottle of orange juice from the nurses' cart and drunk the bottle. She stated luckily it was edible, but after that incident they had to keep the orange juice locked on the carts. LVN A stated the body wash should not have been out in Residents #2's room because it was memory care, and the residents did not know they were not supposed to ingest the body wash. She stated body wash was supposed to be kept in shower rooms, which were locked. LVN A stated families come to visit and sometimes they leave the residents' things to use, and the staff were unaware. She stated the nurses were supposed to do weekly sweeps. She stated she had not worked in memory care this week, so she did not know if they had completed a sweep. She stated after the incident with Resident #1, staff was in-serviced, and they did a swept to remove any dangerous items. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 02/15/23 at 10:46 AM, CNA B stated she was responsible for Residents #4 and #5. She stated Resident #4 was not ready to get out of bed, but she did get Resident #5 up. CNA B stated she changed Resident #5's brief, got her out of bed, and on the way out of the room, Resident #5 stopped and washed her hands in the sink. She stated she did not notice the body wash or body lotion on the sink. CNA B stated she did not put the products there nor did she use the products on Residents #4 or #5. CNA B stated she did not know how long the bottles were sitting out. She stated those items are not supposed to be left out and are normally locked in the shower rooms because they could be dangerous for residents. She stated she did get an in-service on 02/07/23 regarding those items should not be left out. CNA B stated she should have been looking would have removed the products, but she just did not notice them on the sink. A record review of the MSDS for the bottle of body lotion that was found on 02/15/23 in Residents #4 and #5's room revealed Hazards Identification: Classification Acute Toxicity-Oral, Eye Damage/Irritation . Hazard Statements: Causes eye irritation, May be harmful if swallowed. A record review of the MSDS for the bottle of body wash that was found on 02/15/23 in Residents #4 and #5's room revealed Hazards Identification: Classification Eye Damage/Irritation . Hazard Statements: Causes eye irritation. In an interview on 02/15/23 at 3:45 PM, the ADMN stated the facility did not have a policy regarding prohibited items in memory care. She stated for in-services they used pages 33 and 34 of the facility's admissions packet, which listed items residents could not have in their rooms. A record review of pages 33 and 34 of facility's admission packets , not dated, did not reveal resident's in memory care could not have soaps, body wash, or lotion; however, there was a Note, which stated the following: A good rule of thumb has been established by the Food and Drug Administration whereby any products labeled keep out of reach of children or carries any type of caution label is merchandise that contains ingredients which are harmful if taken without supervision or used in a way not designated. Many of our residents, due to mental impairments or poor eyesight might inadvertently drink or eat some of the above items causing irreparable harm. The Administrator was notified on 02/15/23 at 4:10 PM, that an Immediate Jeopardy had been identified due to the above failure. The IJ Template was provided to the Administrator on 02/15/23 at 4:13 PM. The Plan of Removal (POR) was accepted on 02/16/23 at 12:28 PM. The Plan of Removal reflected the following: 1. The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome, with completion date of 02/15/23. The DON educated the nurse aide leaving bath wash and lotion in memory care resident's room unattended to ensure hazardous products are not left in reach of memory care residents. The employee was suspended pending investigation. All resident on the Memory Care unit have potential to be affected and were assessed for complications by charge nurse, none were noted. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	All resident rooms and areas on the Memory Care unit were inspected for presence of bath wash and lotion or hazardous products by Administrator, DON, ADONs, department heads, none were noted. Going forward inspections will be carried out by the Interdisciplinary Team. 2. The facility took the following actions to prevent an adverse outcome from reoccurring, with completion date 02/15/23. The DON/Nursing Administration staff provided education to all staff on ensuring hazardous products are not left in reach of memory care residents. Bathing and lotion products are to be securely stored when not in use. All PRN Staff, Agency staff and staff not currently working will be in-serviced prior to their next shift on ensuring hazardous products are not left in reach of memory care residents. Orientation and training for new hires will include education to staff related to ensuring hazardous products are not left in reach of memory care residents. Review of the products showed they did not include keep out of reach of children, staff were instructed to read precautions of product use and check with the charge nurse when there is a question about products that are safe to leave in a resident's room. The facility Interdisciplinary Team Leaders will audit resident rooms daily to ensure compliance with the facility policy. Findings will be reported in daily QA Meeting. The Administrator/Maintenance Director will audit resident rooms weekly to validate compliance with facility policy. A QAPI PIP has been initiated to report on the above monitoring and auditing procedures. All findings from the PIP will be presented at the monthly QAA meeting. Monitoring of the facility's Plan of Removal included the following: A record review of the medical records for the 47 residents in the memory care unit revealed they were assessed for complications by the charge nurse and there were no issues. Further review of the 47 residents' medical records revealed there were progress notes indicated their families had been contacted and advised not to leave prohibited items in the resident's rooms. Observations on 02/16/23 from 2:00 PM to 2:05 PM revealed all rooms and areas in the memory care unit were free from hazardous products. Interviews were conducted on 02/16/23 from 1:25 PM to 2:40 PM with the Administrator, DON, Activity Director, Activity Assistant, Staff Coordinator, 1 RN, 7 LVNs, 10 CNAs, 2 housekeeping, and 3 therapy staff from multiple shifts. The staff all indicated they had been in-serviced on safety awareness, which included a list of prohibited items in memory care, how hazardous items should be stored, the procedures on storing prohibited items that family members might bring for resident use, and procedures in case they were not sure if an item is hazardous. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of the in-services dated 02/15/23 on Safety Awareness, No soaps, chemicals, colognes, shaving creams, cleaning supplies of any kind left in resident's rooms on Memory Care, and All staff to read the precautions of a product use and check with charge nurse when there is a question about products are safe to leave in a resident's room revealed 56 signatures from multiple shifts and multiple departments (RNs, LVNs, Therapy, Housekeeping, Laundry, Maintenance, and Administration) had received in-services which covered all aspects of the POR . A record review of document titled Facility: Room Sweep, dated 02/15/23 to 02/16/23, revealed the facility's Interdisciplinary Team Leaders had conducted room sweeps for all rooms in the memory care unit. Each room number (120-332) was listed on the form and the Interdisciplinary Team Leaders who inspected the room had provided their signatures on the document. The Administrator was informed the Immediate Jeopardy was removed on 02/16/22 at 2:50 PM; however, the facility remained out of compliance at a scope of pattern and a severity of potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems.