STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676453	A. BUILDING _____ B. WING _____	**08/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIMPSON PLACE	**3922 SIMPSON STREET DALLAS, TX 75246**

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 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have evidence that an allegation of neglect was thoroughly investigated for one of one facility self-reported incident investigated. The Abuse and Neglect Coordinator failed to thoroughly investigate an incident alleging neglect of Resident #1, who had a [DIAGNOSES REDACTED]. This failure could place residents at risk for falls, injuries, burns, seclusion and emotional trauma. Findings included: Review of Resident #1's quarterly MDS assessment dated [DATE] revealed she was a [AGE] year old female admitted to the facility on [DATE]. She had severe cognitive impairment and her active [DIAGNOSES REDACTED]. She had unclear speech and was sometimes understood by others. She required extensive assistance of two staff for transfers, dressing, toilet use and personal hygiene. She was not steady with balance during walking and transitions unless she had staff assistance. She was ambulatory and required no devices. The MDS reflected she was noted to be frequently incontinent of bowel and bladder and a bowel and bladder toileting program was not currently being used to manage her bowel incontinence. Review of Resident #1's care plan dated 03/01/19 and last updated during the investigation on 07/29/20, revealed Resident #1 was a fall risk as evidenced by a fall, problems with balance, generalized weakness, severely impaired cognitive status and incontinence. On 07/29/20 at 1:19 PM video footage from video monitoring of Resident #1's room provided by the resident's POA was reviewed on the ADM's laptop. The video footage was in three clips and revealed on 07/19/20 at approximately 7:08 AM, NA A came in to Resident #1's bedroom and tried to wake her up. NA A got the resident up from the bed, got some clothes from the dresser and walked her to the bathroom, went in with her and closed the door. NA A left the bathroom with the resident's gown a few minutes later. NA A then left the room (with the bathroom door closed and Resident #1 in it) for about 20 minutes. Around 7:55 AM, NA A comes into Resident #1's room, made her bed, lowered it, got gloves from the box on the wall and then left the room. Around 8:32 AM, CNA B entered the room and served Resident #1's roommate (Resident #2) her breakfast tray in bed. Around 8:42 AM, Resident #1 can be seen opening the bathroom door and shuffling out with small steps, her brief was around her knees and her pants/tights were around her ankles. She walked towards her bed. CNA B then see her and continues to put creamer in Resident #2's coffee while Resident #1 stood there. CNA B then went to pull up Resident #1's brief and pants, then went into the bathroom, had a trash can in her hand and then NA A came into the room. NA A left and went into the hallway. Review of the facility's investigation of the incident that involved Resident #1 being left in the bathroom by herself for over an hour, revealed the ADM completed the investigation on 07/27/20 and submitted to HHSC. The incident was categorized as neglect. Initially, no alleged perpetrator was listed on the self-report to HHSC and no witnesses were noted as being present. The provider response indicated the investigation was completed, the medical director was notified, staff interviews were conducted and safe surveys were done with the residents. The investigation summary reflected that the ADM received a concern from Resident #1's daughter that she was left in the bathroom during toileting and had not received timely care. The ADM reviewed the video footage provided by the RP as the family had a camera in the resident's room. Resident #1 was taken to the bathroom and the aide stayed in the bathroom with the resident, then left and picked up her room and failed to check on the resident. The resident then came out of the bathroom and another CNA was able to assist the resident. The ADM stated in the findings the resident did not sustain any adverse effects and interviews completed with staff resulted with any (sic) allegations of neglect. Staff education was noted as having been provided directly to the aide. The ADM dispositioned the allegation of neglect as unfounded. Review of the statements related to the incident obtained by the ADM during his investigation revealed he interviewed six staff (three nurses, a medication aide, a housekeeper and an unknown). None of the staff interviewed had any knowledge of the incident because they did not work the day it occurred. Only one nurse indicated she spoke with family, staff and management about the incident, but there were no further details documented. The investigation by the facility did not include any statements obtained from the alleged perpetrator (NA A) and witness (CNA B) or an interview with the roommate (Resident #2) who was present during the incident. It also did not reflect the time frames from the video that indicated how long the resident was left in the bathroom alone and how she appeared when she came out. Interview with Resident #1's RP on 07/28/20 at 9:33 AM revealed she observed through the video camera in the room, that on 07/19/20, a staff member took Resident #1 into the bathroom at 7:07 AM and left her there. At the time, Resident #1 already had a fractured thumb from a fall she had in the facility 07/15/20. The RP said Resident #1 could be seen on the video camera shuffling out of the bathroom at 8:33 AM. She said the staff member left Resident #1 in the bathroom for an hour and 25 minutes. She notified the ADM via email that day. The RP said the facility never responded to her concern of the staff member leaving her mother in the bathroom for almost an hour and a half. She said after she reported the video and findings to the ADM via email, she never heard back from him about it. Interview with the DON on 07/28/20 at 3:29 PM revealed Resident #1 was left in the bathroom and had seen part of the video the RP had sent in on the incident. The DON said in the video(s) she saw, the CNA left the resident in the bathroom by herself for 30 minutes when Resident #1 came out of the bathroom on her own with her brief pulled up halfway to her thighs. As a result of the incident, she said she did an in-service with that staff member and staff that they have to stay in the bathroom with Resident #1 until she was finished and that was going to be a new intervention. She said Resident #1 did not know how to use the emergency call light and the bathroom door that was shut was heavy. She said she did an in-service for falls, neglect and abuse. The DON said, I don't feel like (NA A) did anything wrong. Interview with the ADM on 07/29/20 at 11:05 AM revealed he called in the incident of neglect to HHSC on 07/20/20. He said it was brought to his attention by the RP of Resident #1 as she had video footage of it. He was not sure if the incident happened on Saturday or Sunday, but he saw the email from the RP on Monday 07/20/20. He said he reviewed the video footage from the RP and confirmed NA A left Resident #1 in the bathroom for over an hour. He said he and the DON talked to NA A but she did not remember leaving Resident #1 in the bathroom. He said his main issues was that NA A did not check on Resident #1 and left her there. He said, She knew there was a camera so if anything, put on a show for this camera, but I don't think it was intentional. I think it was more of an educational issue and we reassigned her. He said she was a new aide they had hired during the pandemic of COVID-19 and they used the waiver on her so she was not a certified nurse aide and only had a temporary certification right now. An interview with NA A on 07/29/20 at 12:34 PM revealed she got her temporary certification three months ago and prior to that, she worked at the facility in housekeeping. She said since she was new to the position, she did not work on her own and always had a leader. She said she found out who her leader was at the start of every shift and the nurse told her who it would be. She said everyone knew she was still in training and she did not do things by herself. Regarding Resident #1, she said she saw part of the video and she did not understand because she never left her in the bathroom. She said, I think(NAME)went into the bathroom by herself because I dress her up, I fix everything and send her to the hallway. NA A said she felt the videos were not clear and the time was not clear, so they may be from different times. She confirmed the first video showed her taking Resident #1 to the bathroom. She said she remembered the day of the incident. She said she went to Resident #1's room to wake her up and she said no. So, she gave her some time and tried again to wake her and dress her for breakfast around 6:45 AM. She said no, so NA A came back around 7:00 AM and she was able to wake her up and take her to the bathroom.

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

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

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Then she saw CNA B coming out of the bathroom and I saw them. She said CNA B asked her if she put Resident #1 in the bathroom, and NA A said no. She said she saw that Resident #1's clothes were pulled down so she put down the breakfast tray and fixed everything. NA claimed when she took Resident #1 to the bathroom earlier, she took her out and walked her to the hallway. She insinuated Resident #1 may have gone into the bathroom on her own, even though she had never seen her do that before. NA A said she knew that Resident #1 was never to be left in the bathroom by herself. An interview with CNA B on 07/29/20 at 1:59 PM revealed that she was setting up Resident #2's breakfast when someone came out of the bathroom and it startled her. She said, (Resident #1), what are you doing? She said she went to the bathroom and her pants were down. CNA B said she told Resident #1 not to sit on her bed. She finished putting sugar and creamer in Resident #2's coffee and put her jelly on bread, sanitized her hands and pulled Resident #1's pants up. CNA B said, She really scared me. CNA B stated she never saw NA A in the room prior to that. She said she asked NA A if she put Resident #1 in the bathroom and she said no. She said she got her up, put her in bathroom, and then sat her on the sofa. CNA B said she did see Resident #1 on the sofa that morning because she had woken up and come into the hallway. That's how they knew she was out of bed. She said the resident did not go back to bed after that. CNA B said once you get Resident #1 up and lay her back down, she won't want to get back up. CNA B said she knew Resident #1 could not be left in the bathroom by herself since she started working at the facility. She said she had told NA A never to leave the resident on the toilet, just stay there until she finished. CNA B said she had never seen Resident #1 use the bathroom on her own. Interview with the ADM on 08/01/20 at 6:43 PM revealed he talked to NA A briefly and showed her a small part of the video but then got side tracked to something else. He said he did not show her the whole videos series. He said she claimed she did not leave her in there that long. He said he did not circle back and talk to her about the fact that she did, in fact, leave her in the bathroom for over an hour. He said he talked to CNA B, but did not have any documentation of it. He said he did not speak to the other witness (Resident #2) and did not indicate why. Review of the facility's Training In-Service Form revealed it was dated 07/18/20 but the date was crossed out and updated to 07/20/20. The training was titled Take a Stand to Prevent Falls and was conducted by the DON. The training roster/signature sheet was observed to be an exact photocopy of a training the DON had done prior to the incident with Resident #1 with just the date crossed out and changed and signed off on by the DON. The training subject and the training materials reviewed did not include any information on residents with dementia and supervision during toileting, or anything specific to Resident #1's individualized supervision needs while in the bathroom or leaving a resident alone for an extended period of time and the associated risks that could occur besides falls. Review of the facility's Internal Investigation Guidelines policy (undated) reflected .8. Investigation: Please refer to the best practices in 'Internal Investigation Guidelines'. The Abuse Coordinator or designated representative will immediately begin an investigation and follow the State Guidelines for reporting incidents and accidents. Such investigation guidelines include a. Resident(s) and responsible party interviews, as applicable; b. Physical examination of the resident, if applicable; c. Staff interviews and written statements, as applicable; d. Collaboration with state agencies; e. Methods to support the individual and detect and prevent further victimization.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to develop, review and revise care plans to ensure it was individualized and addressed the needs for one (Residents #1) of one resident whose care plan was reviewed for accuracy. The facility failed to develop an accurate individualized comprehensive care plan which identified Resident #1's individual toileting schedule. This failure could place residents at risk of receiving inadequate interventions not individualized to their care needs. Findings included: Review of Resident #1's quarterly MDS assessment dated [DATE] revealed she was a [AGE] year old female admitted to the facility on [DATE]. She had severe cognitive impairment and her active [DIAGNOSES REDACTED]. She had unclear speech and was sometimes understood by others. She required extensive assistance of two staff for transfers, dressing, toilet use and personal hygiene. She was not steady with balance during walking and transitions unless she had staff assistance. She was ambulatory and required no devices. The MDS reflected she was noted to be frequently incontinent of bowel and bladder and a bowel and bladder toileting program was not currently being used to manage her bowel incontinence. Review of Resident #1's care plan dated 03/01/19 and updated on 11/26/19, 05/30/19 and 07/29/20 related to problems with elimination included she was sometimes/usually mentally unaware of toileting needs and had severely impaired cognitive status. Her interventions were to assist to toilet as needed, encourage fluids, keep call light in reach and remind to call for assistance. Also, to monitor bowel movements daily, observe pattern of incontinence and initiate toileting schedule or prompted voiding if indicated, provide peri-care, take resident to the toilet at the same time each day resident had a bowel movement and therapy referral as indicated. Review of Resident #1's Care Plan Conference Summary dated 07/16/20 revealed it was a quarterly care plan update. Resident #1's representative, the facility social worker, nursing staff, hospice staff and local Ombudsman were participants in the meeting. Resident #1's toileting schedule was discussed and reflected, Rather than specific times listed on the care plan, there will be ranges. Review of Resident #1's Care Plan Conference Summary dated 07/23/20 revealed it was a care update. Resident #1's representative, social worker, nursing, hospice staff and local Ombudsman were noted to have participated. Resident #1's toileting program was discussed and reflected, Comment Reviewed resident's toileting schedule. Rather than specific times listed on care plan, there will be ranges: 1:00-2:00 am, 7:00-8:00 am, 9:30-10:30 am (and teeth brushed), 1:30-2:30 pm, 4:00-5:00 pm, 6:30-7:30 pm (and teeth brushed), 9:00-10:00 pm. Review of Resident #1's individualized care plan on 07/29/20 at 3:07 PM revealed it had not been updated since March 2020. The care plan did not reflect the resident's fall with thumb fracture, her individualized toileting schedule, or supervision needs while in the bathroom. Review of grievances filed by Resident #1's RP revealed the family filed grievances related to the resident not being toileted as scheduled. The RP filed these grievances after noting care not being provided through the AEM: 02/04/20: Resident not washing her hands after toileting, not being provided fluids at bedside, and housekeeping was not cleaning the room. 02/14/20: Resident missed a toileting time. ADM confirmed it was not done as CNA was busy feeding another resident and thought someone else had done it. 03/09/20: Resident missed a toileting time on 03/08/20. 03/16/20: Resident missed a toileting time and requested a UA/culture to be done. 03/30/20: Resident was left in her bed from the night before until 12:45p.m. 04/07/20: Resident missed a scheduled toileting time the day before. Interview with Resident #1's RP on 07/28/20 at 9:33 AM revealed the facility continued to struggle with toileting her mother according to the toileting schedule. The RP stated she had a video camera in Resident #1's room so she could observe when the staff were taking the resident to the bathroom. She expressed concern that Resident #1 was prone to urinary tract infections and that toileting her routinely could help potentially prevent infections. The RP said the agreed upon toileting times for Resident #1 had always been: 1:00 AM, 7:00 AM, 9:30 AM, 1:30 PM, 4:00 PM, 6:30 PM and 9:00 PM. The RP felt those were reasonable times for a woman who had end stage dementia and was 100% incontinent. The RP stated none of those times could be missed because of the risk of a UTI. She said she understood the staff could not always hit the exact time on the nose, so she agreed to there being some flexibility within 15-20 minutes of toileting times. An interview with the DON on 07/29/20 at 3:08 PM revealed she did not see a current and updated care plan for Resident #1. She said the toileting schedule should have been on the care plan, but she could not see it. She said she was going to have the MDS coordinator print it out. Observation and record review of the facility's electronic charting system revealed on 07/29/20 at 3:25 PM, Resident #1's care plan was in the process of being updated in live time after it was asked to be printed. All goals and interventions were changed to the current date of 07/29/20. Interview with the MDS Coordinator on 07/29/20 at 3:47 PM revealed Resident #1's toileting program was changed during the most recent care plan conference due to some conflicts with the time frames. He said members of the IDT were going back and forth on it and from what he understood, neither the facility or the RP were happy with the results. He said he thought the DON and ADON were the staff who care planned the toileting schedule because they did acute care plans and he did not have access to all the changes. He said his role was to care plan off the MDS assessment, not issues or changes that came up in between the scheduled assessments. An interview with the DON on 07/29/20 at 4:07 PM revealed the information discussed by the IDT during care plan conference meetings, such as a toileting scheduled for Resident #1, did not have to be documented in the care plan. She said the nurses could see the notes that were written in the care plan conference summary and they would reference that, not the care plan.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate**

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) **supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent an accident for one (Residents #1) of three residents reviewed for incidents/accidents. The facility failed to supervise Resident #1, who had [MEDICAL CONDITION] and needed two-person physical staff assistance, in the bathroom by herself for about an hour and a half by a nurse aide with the door shut. These failures had the potential to affect residents with ambulation and transfer needs by placing them at risk for injuries including fractures, skin tears, pain and burns. Findings included: Review of Resident #1's quarterly MDS assessment dated [DATE] revealed she was a [AGE] year old female admitted to the facility on [DATE]. She had severe cognitive impairment and her active [DIAGNOSES REDACTED]. She has unclear speech and was sometimes understood by others. She has no behavioral issues, no rejection of care and had wandering behaviors noted to be daily. She required extensive assistance of two staff for transfers, dressing, toilet use and personal hygiene. She required one person to physically assist her with eating. She was total dependence on bathing and was not stead with balance during walking and transitions unless she had staff assistance. She was ambulatory and required no devices. The MDS reflected a toileting program trail was attempted on admission but was not currently being used to manage the resident's urinary incontinence. She was noted to be frequently incontinent of bowel and bladder and a bowel toileting program was not currently being used to manage her bowel incontinence. The assessment also reflected she received hospice care. Review of Resident #1's care plan dated 03/01/19 and updated on 11/26/19, 05/30/19 and 07/29/20 related to problems with elimination included she was sometimes/usually mentally unaware of toileting needs and had severely impaired cognitive status. Her interventions were to assist to toilet as needed, encourage fluids, keep call light in reach and remind to call for assistance, monitor bowel movements daily, observe pattern of incontinence and initiate toileting schedule or prompted voiding if indicated, provide peri care, take resident to toilet at same time each day resident has a bowel movement and therapy referral as indicated. Review of Resident #1's Medical Power of Attorney and Statutory Durable Power of Attorney revealed her two daughters and husband were equally appointed as her agent on 09/20/17. Interview with Resident #1's RP on 07/28/20 at 9:33 AM revealed she observed through the video camera in the room, that on 07/19/20, an CNA took Resident #1 into the bathroom at 7:07 AM and left her there. At the time, Resident #1 already had a fractured thumb from a fall she had in the facility 07/15/20. The RP said Resident #1 could be seen on the video camera and shuffled out of the bathroom at 8:33 AM. She said the CNA left her in the bathroom for an hour and 25 minutes on the toilet. She notified the ADM via email that day. The RP said the facility never responded to her concern of the CNA leaving her mother in the bathroom for almost an hour and a half. On 07/29/20 at 1:19 PM, the video footage in a series of three clips provided from the RP to the ADM was reviewed on his laptop and revealed on 07/19/20 at approximately 7:08 AM, NA A came in to Resident #1's bedroom and tried to wake her up. She got her up from the bed, got clothes from her dresser, walked her to the bathroom, went in with her and closed the door. She left the bathroom with her gown a few minutes later. She then left the room (with the bathroom door closed and Resident #1 in it) for about 20 minutes. Around 7:55 AM, NA A comes into Resident #1's room, made her bed, lowered it, got gloves on the wall and left the room. Around 8:32 AM, CNA B enters the room and serves Resident #2 her breakfast tray in bed. Around 8:42 AM, Resident #1 can be seen opening the bathroom door and shuffling out with small steps, he brief was around her knees and her pants/tights are around her ankles. She walked towards her bed. CNA B then see her and continues to put creamer in Resident #2's coffee while Resident #1 stood there. She then goes to pull up Resident #1's brief and pants, then goes into the bathroom, had a trashcan in her hand and then NA A came into the room. NA A left and went into the hallway. Interview with the DON on 07/28/20 at 3:29PM revealed Resident #1 was left in the bathroom and had seen part of the video the RP had sent in on the incident. The DON said in the video(s) she saw, the CNA left the resident in the bathroom by herself for 30 minutes when Resident #1 came out of the bathroom on her own with her brief pulled up halfway to her thighs. As a result of the incident, she said she did an in-service with that CNA and staff that they have to stay in the bathroom with Resident #1 until she is finished and that was going to be a new intervention. She said Resident #1 did not know how to use the emergency call light and the bathroom door that was shut was heavy. She said she did an in-service for falls, neglect and abuse. The DON said, I don't feel like the CNA did anything wrong. Interview with the ADM on 07/29/20 at 11:05 AM revealed he called in the incident of neglect to HHSC on 07/20/20. He said it was brought to his attention by the RP of Resident #1 as she had video footage of it. He was not sure if the incident happened on Saturday or Sunday, but he saw the email from the RP on Monday 07/20/20. He said he reviewed the video footage from the RP and confirmed CNA A left Resident #1 in the bathroom for over an hour. He said he and the DON talked to CNA A but she did not remember leaving Resident #1 in the bathroom. He said his main issues was that CNA A did not check on Resident #1 and left her there. He said, She knew there was a camera so if anything, put on a show for this camera, but I don't think it was intentional. I think it was more of an educational issue and we reassigned her. He said she was a new aide they had hired during the pandemic of COVID-19 and they used the waiver on her so she was not a certified nurse aide and only had a temporary license right now. An interview with NA A on 07/29/20 at 12:34PM revealed she got her temporary license three months ago and prior to that, she worked at the facility in housekeeping. She said since she was new to the position, she did not work on her worn and always had a leader. She said she found out who her leader was at the start of every shift and the nurse told her who it would be. She said everyone knew she was still in training and she did not do things by herself. Regarding Resident #1, she said she saw part of the video and she did not understand because she never left her in the bathroom. She said, I think(NAME)went into the bathroom by herself because I dress her up, I fix everything and send her to the hallway. NA A said she felt the videos were not clear and the time was not clear, so they may be from different times. She confirmed the first video showed her taking Resident #1 to the bathroom. She said she remembered the day of the incident. She said she went to Resident #1's room to wake her up and she said no. So, she gave her some time and tried again to wake her and dress her for breakfast around 6:45 AM. She said no, so NA A came back around 7:00 AM and she was able to wake her up and take her to the bathroom. Then she saw CNA B coming out of the bathroom and I saw them. She said CNA B asked her if she put Resident #1 in the bathroom, and NA A said no. She said she saw that Resident #1's clothes were pulled down so she put down the breakfast tray and fixed everything. NA claimed when she took Resident #1 to the bathroom earlier, she took her out and walked her to the hallway. She insinuated Resident #1 may have gone into the bathroom on her own, even though she had never seen her do that before. NA a said she knew Resident #1 was never to be left in the bathroom by herself. An interview with CNA B on 07/29/20 at 1:59 PM revealed that she was setting up Resident #2's breakfast when someone came out of the bathroom and it startled her. She said, (Resident #1), what r u doing? She said she went to the bathroom and her pants were down. CNA B said she told Resident #1 not to sit on her bed. She finished putting sugar and creamer in Resident #2's coffee and put her jelly on bread, sanitized her hands and pulled Resident #1's pants up. CNA B said, She really scared me. CNA B stated she never saw NA A in the room prior to that. She said she asked NA A if she put Resident #1 in the bathroom and she said no. She said she got her up, put her in bathroom, and then sat her on the sofa. CNA B said she did see Resident #1 on the sofa that morning because she had woken up and come into the hallway. That's how they knew she was out of bed. She said the resident did not go back to bed after that. CNA B said once you get Resident #1 up and lay her back down, she won't want to get back up. CNA B said she knew Resident #1 could not be left in the bathroom by herself since she started working at the facility. She said she had told NA A never to leave the resident on the toilet, just stay there until she finished. CNA B said she had never seen Resident #1 use the bathroom on her own. An interview with the DON on 07/29/20 at 3:02 PM revealed the ADM was in charge of investigating any allegations related to Resident #1. He said she did an in-service after the incident of NA A leaving her in the bathroom. She said there was a fall in-service that talked about everyone being responsible for falls. She said there should be a note/intervention in her care plan about staying with her in the bathroom, but there was no specific training done related to that incident and her individualized supervision need during toileting. She also indicated the CNAs could not see the care planned interventions and it was the nurse's responsibility to endure the CNAs were following the care plan. The DON said again hat she did not see all the videos and did not train to the exact issue and did not know Resident #1 was left alone in a closed bathroom for an extended period of time. Interview with the ADM on 08/01/20 at 6:43PM revealed once surveyor brought up a concern NA A and staff were not trained about the intervention of not leaving Resident #1 alone in the bathroom and her supervision needs, the DON in-serviced them on 07/30/20. Record review on 08/01/20 at 6:56 PM indicated the ADM provided a 1:1 in-serviced the DON completed with NA A on 07/30/20 as well as with nursing staff, after surveyor intervention. The training was titled (Resident #1's) Solutions for Incontinence and Toileting Challenges. However, Resident #1' care plan remain unchanged and

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SIMPSON PLACE	**3922 SIMPSON STREET DALLAS, TX 75246**

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 -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) did not include the need to provide supervision at all times during toileting.