STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675611	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Dallas	550 E Ann Arbor Ave Dallas, TX 75216

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054 Based on interview and record review, the facility failed to ensure the residents' right to be free from abuse for one (Resident #1) of eight residents reviewed for abuse. -The facility failed to have interventions in place to prevent Resident #1 from being abused by Resident #2, who had a history of being aggressive with no interventions care planned until 06/06/24, after the incident. On 06/05/24 Resident #1 wandered into Resident #2's room where he was physically attacked and sustained a serious injury. The non-compliance was identified as past non-compliance (PNC). The IJ began on 06/05/24 and ended on 06/06/24. The facility had corrected the non-compliance before the state's investigation began. These failures could place all residents at risk for abuse that could lead to serious injury, harm, impairment, or death. Findings included: 1. Record review of Resident #1's face sheet, dated 06/10/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included: dementia (loss of memory and thinking), traumatic brain injury, dysphasia (difficulty speaking), unsteadiness on feet, and age-related physical debility (weakness caused by age). Record review of Resident #1's quarterly MDS assessment, dated 03/0724, reflected his BIMS score was 03, which indicated severe cognitive impairment. Record review of Resident #1's care plan, revised 01/30/24, reflected the resident was at risk for impaired thought processes r/t traumatic brain injury with cognitive deficit, new facility, and seizure disorder, with interventions that included communication (identifying self at each interaction, face when speaking, reduce distractions, use simple directives, and provide necessary cues-stop and return if agitated). (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's hospital records, dated 06/05/24, reflected the following: [Resident #1] is a [AGE] year-old male who presents s/p being pushes at his nursing facility in which patient hit his head. Patient has a history of prior head trauma for which he underwent craniectomy and cranioplasty. His [family] was at bedside to help provide history. [Family] reports that he is more confused than usual because he cannot remember his birthdate. On exam, he is able to tell us the date and month of his birthday but mixes up the year. [Resident #1] denied pain and had no obvious signs of trauma. Further review reflected results from a CT scan completed on 06/05/24 with findings of an epidural hematoma (bleed between skull and brain matter and postsurgical changes of right frontal craniotomy (surgical opening of skull) and left pterional craniectomy (brain surgery). Record review of Resident #1's progress note, dated 06/05/24 by LVN A, reflected the following: At about 6:00pm, this writer heard a sound of a fall in the hallway. Upon getting there, found [Resident #1] on the floor lying on his back unconscious with [Resident #2] standing over him. The [Resident #2] said 'I pushed him because I don't want him coming in my room'. Head to toe assessment was done. [Resident #1] was unconscious, no visible injuries was noted unable to follow commands. Respiration even labored, unable to move extremities. EMS was called. [Resident #1] regained consciousness at about 6:15PM before 911 arrival . [Resident #1] then was transported to [local hospital] for treatment and evaluation. NP on-call, DON, ADON, Administrator and family notified. 2. Record review of Resident #2's face sheet, dated 06/10/2024, reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included: dementia (loss of memory and thinking), cerebral infarction (stroke), congestive heart failure (weakened heart condition that cause a buildup of fluid in the body), chronic kidney disease, and embolism of pulmonary (blood clot in lungs). Record review of Resident 2's PPS MDS assessment, dated 05/07/24, reflected his BIMS score was 13, which indicated cognition was intact. Record review of Resident #2's care plan, revised 06/06/24, reflected the resident had the potential to demonstrate physical behaviors r/t dementia, poor impulse control with intervention which included: monitor/document/report to MD of danger to self or others., psychiatric consult as indicated, and transfer to hospital for evaluation and treatment for other medical conditions. Further review reflected there were no interventions in place to address Resident #2's aggressive behaviors prior to 06/06/24. Record review of Resident #2's progress note, dated 12/21/23 by LVN A, reflected the following: [Resident #2] tried to exit the facility twice through the back gate and also through the fence by the dining area. After being stopped twice, he became upset and frustrated. This [nurse] redirected [Resident #2] back to his room. Un [sic] getting there, [Resident #2] saw [Resident #3] and kicked him and [Resident #3] yelled out saying 'He kicked me' and Thia [sic] writer went into the room and removed the attack resident from [Resident #2] room, assessed [Resident #3] from head to toe no injuries and no bruises noted . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #2's EHR reflected the resident was assessed by psychologist on 09/30/23, when he first admitted to the nursing facility, to address adjustment to facility, memory loss and appetite disturbance for an estimated frequency/duration of 4 times a month for 3 months. Further review reflected Resident #2 was evaluated again on 1/10/24 to address mood and aggressive behaviors. Resident #2 was discharged from psychological services in 03/2024. In an interview on 06/07/24 at 9:45 AM with the DON and the Administrator, the DON stated she worked at the facility for 8 years. She stated during dinnertime on 06/05/24 it was reported that the CNAs were assisting residents with eating and LVN A had Resident #1 close to her as he was known to wander; however, she turned to get Resident #1 some water and he wandered into Resident #2's room. The DON stated LVN A heard commotion coming from the room and found Resident #1 on the floor. The DON stated the incident was unwitnessed and she could not state if Resident #1 was pushed to the floor or fell on his own. She stated Resident #2 was alert enough to make some decisions, but he had impulsive thinking. The DON stated Resident #2 would get upset around the 1st of the month because he would get confused and think he needed to leave the facility to go pay his bills, he also thought people were trying to take his money which was why he did not like anyone in his room. The DON stated both Resident #1 and Resident #2 resided on the facility's secured unit for behaviors related to dementia. The Administrator stated he worked at the facility for 1.5 years. He stated the plan was to discharge Resident #2 and there was a discharge meeting with the family scheduled. He stated Resident #2's family agreed to provide 1:1 monitoring of the resident until the facility could find placement. The Administrator stated the facility did not have residents who had aggressive behaviors in general, but any resident who exhibited any type of behaviors, it was related to dementia, and they resided on the facility's secured unit. An attempted interview on 06/07/24 with Resident #1 was unsuccessful due to him being in the local hospital and unable to communicate for an interview. Resident #1 was expected to be discharged from the local hospital and return to the nursing facility on 06/10/24; however, he did not arrive by time of Investigator's exit on 06/10/24. An attempted interview on 06/07/24 with Resident #2 was unsuccessful due to him being in the community with family and not responding to phone call. Resident #2 was discharged from the nursing facility on the evening of 06/07/24 and unable to be observed/interviewed when Investigator returned to the facility on [DATE]. In an interview on 06/07/24 at 1:21 PM., LVN A stated she worked at the facility for almost 5 years. She stated she worked on 06/05/24 when Resident #2 attacked Resident #1. LVN A stated the incident happened during dinnertime when the aides were busy assisting other residents. She stated Resident #1 had finished his meal and she had him near the nurses' station to monitor him closely due to wandering behavior. LVN A stated she turned to get Resident #1 some water when he got up and wandered into Resident #2's room. LVN A stated she heard commotion coming from the room and when she rushed there, she found Resident #1 unconscious on the floor with Resident #2 standing over him. She stated Resident #2 did not like anyone in his room and he informed her that he pushed Resident #1 down for coming in . LVN A stated Resident #2 would sometimes become verbally aggressive towards other residents for going into his room, but she had never seen him get physically aggressive. LVN A stated the other residents did not report or appear to be afraid of Resident #2. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/07/24 at 1:48 PM, the SSD stated she was in the process of finding placement for Resident #2 to be discharged . She stated she had sent out referrals to different facilities and the family agreed with the discharge. The SSD stated the family felt an assisted living environment would be more appropriate for Resident #2 because it would provide more space and privacy. The SSD stated Resident #2 had not exhibited aggressive behaviors prior to the incident to her knowledge; however, the facility still thought it was best to discharge him for the safety of everyone. In an interview on 06/07/24 at 1:55 PM, CNA C stated she worked at the facility for [AGE] years on 2nd shift, 2:00 PM-10:00 PM. CNA C stated she worked on 06/05/24 during the incident between Resident #1 and Resident #2. She stated she was assisting other residents with dinner and did not witness the incident; however, LVN A informed her of what happened. CNA C stated Resident #1 always wandered into Resident #2's room because it used to be his room and he would get confused due to dementia and think that was still his room. She stated the staff would always redirect Resident #1 to his room. CNA C stated Resident #2 would get upset when other residents went into his room, but she had never seen him become physically aggressive. In an interview on 06/07/24 at 2:12 PM, CNA B stated she worked at the facility for 7 months on 2nd shift, 2:00 PM-10:00 PM. CNA B stated she worked on 06/05/24 during the incident between Resident #1 and Resident #2. She stated she was assisting other residents with dinner when she heard a noise and the LVN A yelled for her to come in Resident #2's room to help. CNA B stated when she got in the room, she saw Resident #1 on the floor, and he was unresponsive. She stated Resident #2 was known to have a bad temper and would curse and get upset if a resident went into his room; however, she never observed him become physically aggressive towards anyone. She stated Resident #2 was mostly quiet and stayed to himself in the room. CNA B stated Resident #2's family stayed at the facility with him to help with his behaviors. She stated Resident #1 previously stayed in the room but was moved for Resident #2's family to stay there, and that was why Resident #1 would get confused and wander back into that room. In an interview on 06/07/24 at 3:05 PM, Resident #2's family member stated the facility notified her that Resident #2 had pushed Resident #1 down for entering his room. The family member stated Resident #2 was not usually physically aggressive and knew better then to put his hands on anyone. She stated Resident #2's friend began residing at the facility with him in 12/2023 after Resident #2 attempted to elope from the facility. She stated that was the facility's way of managing Resident #2's behaviors. She stated the facility was not good at implementing interventions and she expressed concerns about Resident #2' care plan to the ombudsman . The family member stated the facility wanted to discharge Resident #2 back in 01/2024 for behaviors but the ombudsman was able to stop it due to the care plan not properly addressing all of Resident #2's needs. In an interview on 06/10/24 at 8:45 AM, the Administrator stated Resident #2 had been discharged to one of the company's assisted living facilities. He also stated the hospital reported that Resident #1 was stable and expected to be discharged back to the facility on this date. The Administrator stated although Resident #2's care plan did not reflect interventions to address his aggressive behaviors, the facility had interventions in place that included psychological services, training staff on dementia related behaviors and abuse/neglect, and staff knowing to closely monitor redirect all resident away from Resident #2's room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/10/24 at 09:52 AM, Resident #1's family member stated she visited the resident on 06/05/24, prior to the incident and he did not seem like himself as he was not talking as much. The family stated later after she had left the facility, she received a call informing her that Resident #1 had been taken to the emergency room after being pushed down by another resident and hitting his head. The family member stated Resident #1 had a previous brain injury and testing showed the recent incident caused further injury. The family member stated she did not have any concerns for abuse or neglect prior to the incident; however, now had concerns about there being enough staff to properly monitor residents to prevent incidents like that from occurring again. She stated Resident #1 often wandered into Resident #2's room because that used to be his room until they moved him. She stated Resident #1 had good rapport with his new roommate and family, and there had been no issues between them. In an interview on 06/10/24 at 4:35 PM with the Administrator and the DON, the DON stated the staff were trained on behaviors related to dementia and knew to monitor for signs and redirect residents when wandering, especially into Resident #2's room. The DON stated Resident #2 was also seeing a psychologist for his behaviors. The DON stated those interventions should have been on Resident #2's care plan; however, she believed that they were care planned back in 12/2023 because she was very thorough and normally care planned any changes immediately. The DON stated she and the MDS Coordinator were very experienced with care planning, and both understood the importance of keeping it updated; however, this was an oversight. The DON stated she may have accidentally erased previous interventions for behaviors when she updated the care plan after the incident occurred on 06/05/24. The DON stated the risk of not having interventions in place to address aggressive behaviors could result in a negative outcome for residents. The Administrator stated his expectation was that care plans addressed all needs for the residents and was updated whenever there was change in condition/behavior to provide staff with interventions on how to provide appropriate care. The Administrator stated the risk of not updating care plans could be not catching something regarding the care of residents. He stated the facility now ensures that all changes in condition/behaviors are captured during daily morning meetings, and the DON and MDS Coordinator work together to make sure everything is addressed. He stated he is also becoming more involved in the care planning process to verify that care plans are updated per policy. The non-compliance was identified as past non-compliance (PNC). The IJ began on 06/05/24 and ended on 06/06/24. The facility had corrected the non-compliance before the state's investigation began. The facility took the following actions to correct the non-compliance prior to the survey: Record review of in-service titled Dealing with difficult behaviors/Abuse, Neglect & Exploitation, dated 06/06/24, reflected all staff were educated by the DON on how to identify and report abuse/neglect and protocols for dealing with behaviors. Record review of Residents #1, #2, #3, #4, #5, #6, #7, and #8'S EHR revealed their care plans were updated and had interventions to address all care needs. Record review of incident/accident reports, from 05/07/24-06/07/24, reflected no other resident-to-resident incidents regarding abuse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews were conducted on 06/10/24-06/07/24 with DON, ADON, MDS Coordinator, and staff who worked with residents on secured unit with behaviors: LVN A (1st shift), CNA B (2nd shift), CNA C (2nd shift), and LVN D (1st shift), CNA E (1st shift), CNA L (2nd shift). All staff were able to provide competency regarding in-service over abuse/neglect and dealing with difficult behaviors. All staff were able to provide examples of abuse/neglect, appropriate interventions, and when and who to report it to. All staff were also able to provide appropriate interventions and protocols to manage aggressive behaviors and behaviors related to dementia. Staff stated they were made aware of any changes in condition or new behaviors by the charge nurses, DON, and also by access to care plans. Record review of the facility's policy titled Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment: Freedom from abuse, neglect, exploitation, revised 12/2023, reflected in part the following: Policy: It is the policy of this facility that each resident has the right to be free from abuse, neglect misappropriation of resident property, exploitation, and mistreatment Procedure: 1. In response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility will: a. Ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injury of unknown origin and misappropriation of resident property, are reported immediately 2.Ensure that alleged violations involving abuse, neglect, exploitation, or mistreatment, including injury of unknown origin and misappropriation of resident property, are reported to: a. The Administrator of the facility b. The State Survey Agency c. Adult Protective Services 3. Ensure that, after receipt of a report of possible abuse, neglect, mistreatment, exploitation, or misappropriation of resident property, steps are immediately taken to protect the identified resident(s). 4. Ensure that the results of all investigations are reported within 5 working days of the incident. 5. Ensure that if the alleged violation is verified, appropriate corrective action is taken. .

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 45054 Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and time frames to meet residents' mental and psychosocial needs for 2 (Resident #1and Resident #2) of 8 residents reviewed for care plans. - The facility failed to document measurable objectives, interventions, or timeframes to address Resident #1's wandering behavior r/t diagnosis of dementia. On 06/05/24 Resident #1 wandered into Resident #2's room and was physically attacked and sustained a serious injury. -The facility failed to document measurable objectives, interventions, or timeframes to address Resident #2's aggressive behaviors after he exhibited combative behaviors in 12/2023. Interventions were not documented on Resident #2's care plan until after an incident occurred on 06/05/24 where he was physically aggressive with Resident #1 and caused serious injury. The non-compliance was identified as past non-compliance (PNC). The IJ began on 06/05/24 and ended on 06/06/24. The facility had corrected the non-compliance before the state's investigation began. This failure could place all residents at risk of not receiving appropriate care and services to meet their needs. Findings included: 1. Record review of Resident #1's face sheet, dated 06/10/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included: dementia (loss of memory and thinking), traumatic brain injury, dysphasia (difficulty speaking), unsteadiness on feet, and age-related physical debility (weakness caused by age). Record review of Resident #1's quarterly MDS assessment, dated 03/0724, reflected his BIMS score was 03, which indicated severe cognitive impairment. Record review of Resident #1's care plan, revised 01/30/24, reflected the resident was at risk for impaired thought processes r/t traumatic brain injury with cognitive deficit, new facility, and seizure disorder, with interventions that included communication (identifying self at each interaction, face when speaking, reduce distractions, use simple directives, and provide necessary cues-stop and return if agitated). Further review of the care plan revealed Resident #1 did not have interventions in place to address his wandering behavior. (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's hospital records, dated 06/05/24, reflected the following: [Resident #1] is a [AGE] year-old male who presents s/p being pushes at his nursing facility in which patient hit his head. Patient has a history of prior head trauma for which he underwent craniectomy and cranioplasty. His [family] was at bedside to help provide history. [Family] reports that he is more confused than usual because he cannot remember his birthdate. On exam, he is able to tell us the date and month of his birthday but mixes up the year. [Resident #1] denied pain and had no obvious signs of trauma. Further review reflected results from a CT scan completed on 06/05/24 with findings of an epidural hematoma (bleed between skull and brain matter and postsurgical changes of right frontal craniotomy (surgical opening of skull) and left pterional craniectomy (brain surgery). Record review of Resident #1's progress note, dated 06/05/24 by LVN A, reflected the following: At about 6:00pm, this writer heard a sound of a fall in the hallway. Upon getting there, found [Resident #1] on the floor lying on his back unconscious with [Resident #2] standing over him. The [Resident #2] said 'I pushed him because I don't want him coming in my room'. Head to toe assessment was done. [Resident #1] was unconscious, no visible injuries were noted unable to follow commands. Respiration even labored, unable to move extremities. EMS was called. [Resident #1] regained consciousness at about 6:15PM before 911 arrival . [Resident #1] then was transported to [local hospital] for treatment and evaluation. NP on-call, DON, ADON, Administrator and family notified. 2. Record review of Resident #2's face sheet, dated 06/10/2024, reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included: dementia (loss of memory and thinking), cerebral infarction (stroke), congestive heart failure (weakened heart condition that cause a buildup of fluid in the body), chronic kidney disease, and embolism of pulmonary (blood clot in lungs). Record review of Resident 2's PPS MDS assessment, dated 05/0724, reflected his BIMS score was 13, which indicated cognition was intact. Record review of Resident #2's care plan, revised 06/06/24, reflected the resident had the potential to demonstrate physical behaviors r/t dementia, poor impulse control with intervention which included: monitor/document/report to MD of danger to self or others., psychiatric consult as indicated, and transfer to hospital for evaluation and treatment for other medical conditions. Further review reflected there were no interventions in place to address Resident #2's aggressive behaviors prior to 06/06/24. Record review of Resident #2's progress note, dated 12/21/23 by LVN A, reflected the following: [Resident #2] tried to exit the facility twice through the back gate and also through the fence by the dining area. After being stopped twice, he became upset and frustrated. This [nurse] redirected [Resident #2] back to his room. Un [sic] getting there, [Resident #2] saw [Resident #3] and kicked him and [Resident #3] yelled out saying 'He kicked me' and Thia [sic] writer went into the room and removed the attack resident from [Resident #2] room, assessed [Resident #3] from head to toe no injuries and no bruises noted . (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2's EHR reflected the resident was assessed by psychologist on 09/30/23, when he first admitted to the nursing facility, to address adjustment to facility, memory loss and appetite disturbance for an estimated frequency/duration of 4 times a month for 3 months. Further review reflected Resident #2 was evaluated again on 1/10/24 to address mood and aggressive behaviors. Resident #2 was discharged from psychological services in 03/2024. In an interview on 06/07/24 at 9:45 AM with the DON and the Administrator, the DON stated she worked at the facility for 8 years. She stated during dinnertime on 06/05/24 it was reported that the CNAs were assisting residents with eating and LVN A had Resident #1 close to her as he was known to wander; however, she turned to get Resident #1 some water and he wandered into Resident #2's room. The DON stated LVN A heard commotion coming from the room and found Resident #1 on the floor. The DON stated the incident was unwitnessed and she could not state if Resident #1 was pushed to the floor or fell on his own. She stated Resident #2 was alert enough to make some decisions, but he had impulsive thinking. The DON stated Resident #2 would get upset around the 1st of the month because he would get confused and think he needed to leave the facility to go pay his bills, he also thought people were trying to take his money which was why he did not like anyone in his room. The DON stated both Resident #1 and Resident #2 resided on the facility's secured unit for behaviors related to dementia. The Administrator stated he worked at the facility for 1.5 years. He stated the plan was to discharge Resident #2 and there was a discharge meeting with the family scheduled. He stated Resident #2's family agreed to provide 1:1 monitoring of the resident until the facility could find placement. The Administrator stated the facility did not have residents who had aggressive behaviors in general, but any resident who exhibited any type of behaviors, it was related to dementia, and they resided on the facility's secured unit. An attempted interview on 06/07/24 with Resident #1 was unsuccessful due to him being in the local hospital and unable to communicate for an interview. Resident #1 was expected to be discharged from the local hospital and return to the nursing facility on 06/10/24; however, he did not arrive by time of Investigator's exit on 06/10/24. An attempted interview on 06/07/24 with Resident #2 was unsuccessful due to him being in the community with family and not responding to phone call. Resident #2 was discharged from the nursing facility on the evening of 06/07/24 and unable to be observed/interviewed when Investigator returned to the facility on [DATE]. In an interview on 06/07/24 at 1:21 PM. LVN A stated she worked at the facility for almost 5 years. She stated she worked on 06/05/24 when Resident #2 attacked Resident #1. LVN A stated the incident happened during dinnertime when the aides were busy assisting other residents. She stated Resident #1 had finished his meal and she had him near the nurses' station to monitor him closely due to wandering behavior. LVN A stated she turned to get Resident #1 some water when he got up and wandered into Resident #2's room LVN A stated she heard commotion coming from the room and when she rushed there, she found Resident #1 unconscious on the floor with Resident #2 standing over him. She stated Resident #2 did not like anyone in his room and he informed her that he pushed Resident #1 down for coming in. LVN A stated Resident #2 would sometimes become verbally aggressive towards other residents for going into his room, but she had never seen him get physically aggressive. LVN A stated the other residents did not report or appear to be afraid of Resident #2. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675611	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Dallas	550 E Ann Arbor Ave Dallas, TX 75216

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 06/07/24 at 1:55 PM, CNA C stated she worked at the facility for [AGE] years on 2nd shift, 2:00 PM-10:00 PM. CNA C stated she worked on 06/05/24 during the incident between Resident #1 and Resident #2. She stated she was assisting other residents with dinner and did not witness the incident; however, LVN A informed her of what happened. CNA C stated Resident #1 always wandered into Resident #2's room because it used to be his room and he would get confused due to dementia and think that was still his room. She stated the staff would always redirect Resident #1 to his room. CNA C stated Resident #2 would get upset when other residents went into his room, but she had never seen him become physically aggressive. In an interview on 06/07/24 at 2:12 PM, CNA B stated she worked at the facility for 7 months on 2nd shift, 2:00 PM-10:00 PM. CNA B stated she worked on 06/05/24 during the incident between Resident #1 and Resident #2. She stated she was assisting other residents with dinner when she heard a noise and the LVN A yelled for her to come in Resident #2's room to help. CNA B stated when she got in the room, she saw Resident #1 on the floor, and he was unresponsive. She stated Resident #2 was known to have a bad temper and would curse and get upset if a resident went into his room; however, she never observed him become physically aggressive towards anyone. She stated Resident #2 was mostly quiet and stayed to himself in the room. CNA B stated Resident #2's family stayed at the facility with him to help with his behaviors. She stated Resident #1 previously stayed in the room but was moved for Resident #2's family to stay there, and that is why Resident #1 would get confused and wander back into that room. In an interview on 06/07/24 at 3:05 PM, Resident #2's family member stated the facility notified her that Resident #2 had pushed Resident #1 down for entering his room. The family member stated Resident #2 was not usually physically aggressive and knew better then to put his hands on anyone. She stated Resident #2's friend began residing at the facility with him in 12/2023 after Resident #2 attempted to elope from the facility. She stated that was the facility's way of managing Resident #2's behaviors. She stated the facility was not good at implementing interventions and she expressed concerns about Resident #2' care plan to the ombudsman/ The family member stated the facility wanted to discharge Resident #2 back in 01/2024 for behaviors but the ombudsman was able to stop it due to the care plan not properly addressing all of Resident #2's needs. In an interview on 06/10/24 at 8:45 AM, the Administrator stated Resident #2 had been discharged to one of the company's assisted living facilities. He also stated the hospital reported that Resident #1 was stable and expected to be discharged back to the facility on this date. The Administrator stated although Resident #2's care plan did not reflect interventions to address his aggressive behaviors, the facility had interventions in place that included psychological services, training staff on dementia related behaviors and abuse/neglect, and staff knowing to closely monitor redirect all resident away from Resident #2's room. The Administrator stated staff also knew to monitor and redirect Resident #1 from wandering into rooms. (continued on next page)

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	675611	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Dallas	550 E Ann Arbor Ave Dallas, TX 75216

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 06/10/24 at 09:52 AM, Resident #1's family member stated she visited the resident on 06/05/24, prior to the incident and he did not seem like himself as he was not talking as much. The family stated later after she had left the facility, she received a call informing her that Resident #1 had been taken to the emergency room after being pushed down by another resident and hitting his head. The family member stated Resident #1 had a previous brain injury and testing showed the recent incident caused further injury. The family member stated she did not have any concerns for abuse or neglect prior to the incident; however, now had concerns about there being enough staff to properly monitor residents to prevent incidents like that from occurring again. She stated Resident #1 often wandered into Resident #2's room because that used to be his room until they moved him. She stated Resident #1 had good rapport with his new roommate and family, and there had been no issues between them. In an interview on 06/10/24 at 11:50 AM, the MDS Coordinato r revealed she worked at the facility for one year. She stated it was her responsibility to initiate care plans when a resident admitted and to update them as needed; however, the DON also assisted with the task due to the large number of residents. She stated care plans needed to be updated at least quarterly and if there was a significant change in a resident's condition/behaviors. The MDS Coordinator stated any changes in condition/behaviors had to be addressed on the care plan immediately after the first occurrence. She stated any changes or issues with the residents were discussed during morning meeting every day, that was when she received knowledge of any changes that needed to be updated on the care plans. The MDS Coordinator stated she could not recall receiving reports that Resident #2 exhibited any aggressive behaviors and did not update his care plan to reflect so. The MDS Coordinator stated the DON would sometimes be aware of changes in condition that she was not aware of, and the DON would update the care plan herself. The MDS Coordinator stated the importance of a care plan was for nursing staff to know how to provide proper care to each individual resident. She stated the risk of not updating care plans as needed could be improper care being provided to the residents, and in Resident #2's case, his aggressive behaviors were not being addresses and placed other residents in danger. In an interview on 06/10/24 at 4:35 PM with the Administrator and the DON, the DON stated the staff were trained on behaviors related to dementia and knew to monitor for signs and redirect residents when wandering, especially into Resident #2's room. The DON stated Resident #2 was also seeing a psychologist for his behaviors. The DON stated those interventions should have been on Resident #2's care plan; however, she believed that they were care planned back in 12/2023 because she was very thorough and normally care planned any changes immediately. The DON stated she and the MDS Coordinator were very experienced with care planning, and both understood the importance of keeping it updated; however, this was an oversight. The DON stated she may have accidentally erased previous interventions for behaviors when she updated the care plan after the incident occurred on 06/05/24. The DON stated the risk of not having interventions in place to address aggressive behaviors could result in a negative outcome for residents. The Administrator stated his expectation was that care plans addressed all needs for the residents and was updated whenever there was change in condition/behavior to provide staff with interventions on how to provide appropriate care. The Administrator stated the risk of not updating care plans could be not catching something regarding the care of residents. He stated the facility now ensures that all changes in condition/behaviors are captured during daily morning meetings, and the DON and MDS Coordinator work together to make sure everything is addressed. He stated he is also becoming more involved in the care planning process to verify that care plans are updated per policy. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The non-compliance was identified as past non-compliance (PNC). The IJ began on 06/05/24 and ended on 06/06/24. The facility had corrected the non-compliance before the state's investigation began. The facility took the following actions to correct the non-compliance prior to the survey : Record review of Residents #1, #2, #3, #4, #5, #6, #7, and #8'S EHR revealed their care plans were updated and had interventions to address all care needs. Interviews on 06/10/24 at 12:30 PM were conducted with the DON and MDS Coordinator revealed they conveyed the understanding that care plans had to be developed at the time of a residents' admission, then updated quarterly and when there was a significant change in a resident's condition and/or behavior. Review of the facility's policy titled Nursing Administration: Care Planning, revised 07/2020, revealed in part the following: Policy: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident. Procedures: . 9. The resident's plan of care-focus, goals, and interventions-are communicated and implemented by the members of the health care continuum accordingly. 10. The residents' plan of care is reviewed and revised on an ongoing basis, quarterly at a minimum and/or as needed with changes in condition.