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Form Approved OMB
No. 0938-0391

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	06/14/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observation, interview, and record review, the facility failed to ensure residents' right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 3 (Residents #1, #2, and #3) of 9 residents reviewed for call lights in reach. Resident #1's call pad was on the floor, under his bed, and not within reach, while he was in bed. Resident #2's call button was on the floor, under his bed, and not within reach, while he was in bed. Resident #3's call button was clipped to his pillow, and not within reach, while he was in his wheelchair at the foot of his bed. These failures could place residents at risk of not having their needs and preferences met and a decreased quality of life. Findings included: Record review of Resident #1's Face Sheet, 06/14/2024, reflected he was, and [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included acute cystitis without hematuria (bladder infection), adult failure to thrive (syndrome of weight loss, decreased appetite and poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms, impaired immune function, and low cholesterol), lack of coordination, and dysphasia (speaks slowly with great difficulty). Record review of Resident #1s MDS Assessment, dated 05/28/2024, revealed Resident #1's BIMS was 3, which indicated severe cognitive impairment. He was dependent for toileting, showers, dressing, personal hygiene and eating. He required extensive assistance in transferring and bed mobility. Record review of Resident #1's Comprehensive Care Plan, dated 06/10/2024, revealed, Focus: At risk for a communication problem r/t Hearing Impairment, Dementia. Interventions: Anticipate and meet needs. Focus: ADL Self Care Performance Deficit r/t weakness and confusion. Intervention: Encourage to use bell to call for assistance. Focus: At risk for falls r/t weakness, dementia, bowel/bladder incontinence. Intervention: Be sure the call light is within reach and encourage to use it to call for assistance as needed. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's Face Sheet, 06/14/2024, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. Diagnoses included malignant neoplasm of prostate (cancerous tumor), type 2 diabetes (problem in the way the body regulates and uses sugar as fuel), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and hypertension (pressure in blood vessels is too high). Record review of Resident #2s MDS Assessment, dated 06/14/2024, revealed no record of Resident #2's BIMS. His cognitive skills were severely impaired, He had an indwelling catheter and was always incontinent of bladder and frequently incontinent of bowel. Record review of Resident #2's Comprehensive Care Plan, dated 06/10/2024, revealed, Focus: ADL Self Care Performance Deficit r/t bed bound, seizures, stroke, brain tumor, dementia. At risk for falls r/t history of recent falls, seizures, stroke, dementia, history of brain tumor. Intervention: Be sure the call light is within reach and encourage to use it to call for assistance as needed. Bed in lowest position. Record review of Resident #3's Face Sheet, 06/14/2024, reflected he was an [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included lack of coordination, and dysphasia (speaks slowly with great difficulty), muscle wasting and atrophy (thinning of muscle mass), chronic kidney disease (kidneys cannot filter blood the way they should), and unsteadiness on feet. Record review of Resident #3s MDS Assessment, dated 06/08/2024, revealed Resident #3's BIMS was 10, which indicated a mild cognitive impairment. He was totally dependent for toileting, showers, dressing and personal hygiene. He was dependent for sit to stand and bed to chair transfers. Record review of Resident #3's Comprehensive Care Plan, dated 06/06/2024, revealed, Focus: At risk for falls r/t weakness, dementia. Interventions: Be sure the call light is within reach and encourage to use it to call for assistance as needed. Keep needed items, water, etc. in reach. An observation on 06/14/2024 at 9:16 AM revealed Resident #1's call pad on the floor under his bed. Resident #1's roommate, Resident #2's call button was on the floor, under the bed and against the wall. Resident #2 was sleeping. In an interview on 06/14/2024 at 9:18 AM, Resident #1 said he did use his call light and it was usually on his bed beside him but could not find it at the moment. He stated he needed assistance to get out of bed and did use the call light to call for assistant when he needed it. An observation and interview on 06/14/2024 at 9:33 AM revealed Resident #3's call button clipped to the pillow at the head of his bed. The button was under the pillow. Resident #3 was in his wheelchair at the foot of his bed. Resident #3 said he was cold and wanted a blanket. When asked if he used his call light, he said he did but could not find it. In an interview on 06/14/2024 at 9:36 AM, the Administrator in Training (AIT) said call lights should be place so residents could reach them. He said residents had a right to use call lights to ensure they can call for assistance when they needed it. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/14/2024 at 9:42 AM, LVN A stated Resident #1 could not get out of bed on his own and needed the call pad to call for assistance as needed. He said Resident #2 was recently admitted to the facility and should have the call button within his reach at all times. He stated Resident #3 required total assistance and should also have his call light accessible to him at all times. He said residents had a right to be able to call for assistance when they needed it. He said if residents did not have access to their call lights, they could try to get up and fall. In an interview on 06/14/2024 at 9:56 AM, CNA B stated all residents should have access to their call light. She stated she checked for call lights when she did rounds but may have forgotten to place some. She said she had not noticed that Reisidents #1, #2, and #3's call lights were not wihtin thier reach. She said all staff were responsible to ensure call lights were answered and placed in reach of residents. She said if the call lights were not in reach, residents could try to get up and fall resulting in an injury. In an interview on 06/14/2024 at 10:41 AM, ADON C stated residents had a right to have call lights in their reach. She stated they need to be able to call for assistance when they require it. She said when resident was not able to call for assistance they often try to meet their own needs and they could fall and hurt themselves. She stated all staff were responsible to ensure call lights were within reach of each resident. She said nurse managers monitor this by rounding. In an interview on 06/14/2024 at 12:43 PM, the DON stated all staff should ensure call lights were placed in reach of residents. She stated not doing this was a safety concern as resident could get up to help themselves and fall. She said she expected staff to watch for any safety issues when they are rounding throughout the day. In an interview on 06/14/2024 at 1:10 PM, ADON D stated call lights should be accessible to all residents no matter their ability to use them or not. He said it was a resident right to be able to call for assistance as needed. In an interview on 06/14/2024 at 2:24 PM, the administrator stated he expected all staff to follow the facility policies. He said resident had a right to have their call lights accessible to them to ensure their needs were met. Record review of the facility's policy titled, Call Light/Bell dated 05/2020, reflected, . 5. Leave the resident comfortable. Place the call device within resident's reach before leaving room. If the call light/bell is defective, immediately report this information to the unit supervisor. Record review of the facility's policy titled, Safety/Resident revised 07/2013, reflected, .1. Place call light within reach of the resident. 7.Conduct room checks routinely by staff members to promote quality of life and ensure safety of residents residing in the facility. Room checks include but not limited to resident observation (wearing appropriate clothing, oral hygiene, assistive devices, etc.) and bedside observation (call lights within reach, no unauthorized medications, ointments, lotions at bedside, infection control, etc.).

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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 supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observation, interview, and record review the facility failed to ensure residents' environment remained as free of accident hazards as is possible; and residents received adequate supervision and assistance devices to prevent accidents, for one (Resident #1) of nine residents reviewed for accident hazards. The facility failed to ensure Resident #1's fall mat was on the floor, next to his bed. This failure could place the resident at risk of injuries from falls and a decreased quality of care. Findings included: Record review of Resident #1's Face Sheet, 06/14/2024, reflected he was, and [AGE] year-old male originally admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included acute cystitis without hematuria (bladder infection), adult failure to thrive (syndrome of weight loss, decreased appetite and poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms, impaired immune function, and low cholesterol), lack of coordination, and dysphasia (speaks slowly with great difficulty). Record review of Resident #1s MDS Assessment, dated 05/28/2024, revealed Resident #1's BIMS was 3, which indicated severe cognitive impairment. He was dependent for toileting, showers, dressing, personal hygiene and eating. He required extensive assistance in transferring and bed mobility. Record review of Resident #1's Comprehensive Care Plan, dated 06/10/2024, revealed, Focus: At risk for a communication problem r/t Hearing Impairment, Dementia. Interventions: Anticipate and meet needs. Focus: ADL Self Care Performance Deficit r/t weakness and confusion. Intervention: Encourage to use bell to call for assistance. Focus: At risk for falls r/t weakness, dementia, bowel/bladder incontinence. Intervention: Be sure the call light is within reach and encourage to use it to call for assistance as needed. Focus: Has had an actual fall r/t: Poor Balance, Poor communication/comprehension, and Unsteady gait. Intervention: 4/19/24 Bed in lowest position. Continue interventions on the at-risk plan. Record review of Resident #1's Order Summary dated 06/14/2024, reflected a low bed and floor mat was ordered on 05/24/2024 and no start or end date noted. Record review of the facility's incident log, dated 06/14/2024, reflected Resident #1 had a fall on 04/19/2024. An observation on 06/14/2024 at 9:16 AM revealed Resident #1 in bed. Resident #1's fall mat was observed in a clean plastic bag folded in half and placed against the wall and at the foot end of the bed. Resident #1's bed was in the lowest position. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/14/2024 at 9:18 AM, Resident #1 said he did not know what the mat was for or why it was there. He said staff always put his bed low. In an interview on 06/14/2024 at 9:42 AM, LVN A stated Resident #1 could not get out of bed on his own. He said Resident #1 did have a recent fall and should have the fall mat placed on the floor beside his bed, when he was in bed. He said Resident #1 was at risk of injury if he had a fall and the fall mat was not placed. He stated the fall mat may have been brought in by therapy but should still be placed on the floor beside Resident #1's bed. In an interview on 0614/2024 at 9:56 AM, CNA B stated she was not sure why Resident #1's fall mat was in a bag against the wall and not placed on the floor beside his bed. She said she would check wiht LVN A but the kardex would indicate each resindet's care needs. She stated Resident #1 was a fall risk and should have the mat beside his bed to ensure his safety in case he had a fall. She said his bed should also be in the lowest position. In an interview on 06/14/2024 at 12:43 PM, the DON stated Resident #1 did have a fall in April. She said there were orders for a low bed and fall mat but the fall mat was not documented in the care plan. She said the management team were scheduled to review care plans today, to ensure they accurately reflect resindet's needs. She said all staff should ensure the bed is low and the floor mat was in place when Resident #1 was in bed but they could only do this if the interventions were documented in the care plan. She stated not doing this was a safety concern because Resident #1 could fall from bed and be injured. She said she expected staff to watch for any safety issues when they rounded. In an interview on 06/14/2024 at 1:10 PM, ADON D stated Resident #1 should have a fall mat and his bed should be in the lowest position when he was in it. He said facility was responsible to ensure the safety of all residents based on their needs. He stated care needs should be accurately reflected in the care plan to ensure staff know each resident's care needs. In an interview on 06/14/2024 at 2:24 PM, the administrator stated he expected all staff to follow the facility policies. He said he expected staff to follow orders and ensure each resident was safe from injury in case of falls. Record review of the facility's policy titled, Safety/Resident revised 07/2013, reflected, .7. Conduct room checks routinely by staff members to promote quality of life and ensure safety of residents residing in the facility. Room checks include but not limited to resident observation (wearing appropriate clothing, oral hygiene, assistive devices, etc.) and bedside observation (call lights within reach, no unauthorized medications, ointments, lotions at bedside, infection control, etc.).