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	02/06/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interview, and record review the facility failed to ensure residents with pressure ulcers received care and treatment consistent with professional standards of practice to promote healing and prevent further development of skin breakdown and infection for one (Resident #45) of four residents reviewed for pressure ulcers (open wound on the skin caused by prolonged pressure to bony prominences). The facility failed to ensure that LVN A cleaned Resident #45's wound to right 5th toe from inside to outside on 02/05/2025. This failure could place the residents with pressure ulcers at risk for worsening of existing pressure ulcers and infection. Findings included: Record review of Resident #45's Face Sheet, dated 02/05/2025, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with sepsis (infection of the blood stream) and muscle weakness. Record review of Resident #45's Comprehensive MDS Assessment, dated 11/01/2024, reflected the resident had a severe impairment in cognition with a BIMS score of 02. Comprehensive MDS Assessment indicated the resident had a pressure ulcer over a bony prominence. Record review of Resident #45's Comprehensive Care Plan, dated 01/13/2025, reflected the resident had a pressure ulcer to right foot related to decreased mobility and one of the interventions was administer treatments as ordered. Record review of Resident #45's Physician Order, dated 01/17/2025, reflected Right foot (5th toe)- cleanse with NS/wound cleanser, pat dry, apply collagen (wound care product that support the wound's healing process) and cover with a dry dressing. (continued on next page)

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

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/05/2025 at 9:59 AM revealed LVN A and the ADON were about to do Resident #45's wound care to the fifth toe of the right foot. LVN A sanitized her hand, put on a pair of gloves, and prepared the things needed for wound care. She prepared some gauze, some normal saline bullets, collagen wound dressing, a 2 by 2 dressing, and a plastic bag. While LVN A was preparing the things needed for wound care, the ADON washed his hands, put on a pair of gloves, and sanitized the resident's table. After the ADON sanitized the overbed table, LVN A placed the things to be used for wound care on the resident's overbed table. Both staff removed their gloves, washed their hands, and put on gowns and gloves. The ADON positioned and stabilized the resident's right leg under a blanket to raise it. LVN A removed the old dressing and threw it on the plastic bag. It was observed that the resident's wound was covered by a small piece of collagen dressing and the skin surrounding the wound was dry and scaly. LVN A removed her gloves, washed her hands, and put on a new pair of gloves. She took some gauzes and poured normal saline on them. She started to clean the skin surrounding skin of the wound by wiping it in circular motion. She did it two times. With the same gauze used to clean the surrounding skin, she cleaned the wound, and at the same time tried to remove the collagen that was on the wound. She removed her gloves, washed her hands, and put on a pair of gloves. She dried the wound with some gauze from outside to inside. After drying the wound, she put the collagen dressing, and covered the wound with a 2 by 2 dressing. The ADON removed the blanket from under the resident's right leg and lowered it to the bed. Both staff removed their gowns and gloves and washed their hands. In an interview with LVN A on 02/05/2025 at 10:20 AM, LVN A stated Resident #45's wound had a small opening that was why the collagen was sticking on the wound. She said she cleaned around the wound first before cleaning the wound. When asked again, she replied again that she started cleaning the surrounding skin of the wound and then moved to the wound. She said her understanding was that the wound must be cleaned from clean to dirty and for her the surrounding skin was cleaner than the wound. When asked if it was possible that whatever germs the gauze got from the surrounding skin were introduced to the wound, she replied yes. When asked if she was supposed to change the gauze when cleaning the wound, she said yes. In an interview with the DON on 02/06/2025 at 8:07 AM, the DON stated she was made aware by LVN A about the findings during wound care. She said she told LVN A that wound should be cleaned from the least contaminated area, meaning the wound itself to the most contaminated area, which was the surrounding skin. She said the wound could be infected if the contaminants from the surrounding skin were introduced to the wound bed. She said in cleaning the wound, the gauze should be discarded after every stroke. She said the expectation was for the wound to be cleaned the right way. She said she already did a one-on-one in-service with LVN A about wound care, and she was enrolled to a wound care training the following month. In an interview with the ADON on 02/06/2025 at 9:41 AM, the ADON stated the purpose of wound care was to remove debris, bacteria, and exudate in the wound to reduce the risk of infection. He said in wound cleaning, the staff start at the center of the wound going outward, ensuring not to spread the bacteria from the outer area back into the wound. He said a new piece of gauze must be used for each stroke to avoid contamination. He said the expectation was the wound would be cleaned from inside to outside and the gauze be changed with every stroke. He said they would conduct an in-service about wound care. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 02/06/2025 at 10:07 AM, the Administrator stated the expectation was for the staff do the right procedure in cleaning the wound to prevent infection. He said he would collaborate with the DON on how to deal with the issue. Record review of facility policy Wound Care Policy/Procedure - Nursing Clinical revised 05/2007 revealed Procedure for Clean Dressing Technique . Wash from the center of the wound to the periphery. Always wash from the area of least contamination to the area of most contamination.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based observations, interviews, and record review, the facility failed to ensure residents who were incontinent of bowel and bladder received appropriate treatment and services to prevent urinary tract infections for one (Resident #42) of three residents observed for Incontinent Care. The facility failed to ensure that CNA D did not wipe Resident #42's perineal (area between the legs) area from back to front while providing incontinent care on 02/05/2025. This failure could place the residents at risk of cross-contamination and development of urinary tract infections. Findings included: Review of Resident #42's Face Sheet, dated 02/05/2025, reflected the resident was a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with acute kidney failure. Review of Resident #42's Comprehensive MDS Assessment, dated 01/22/2025, reflected the resident was cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated Resident #42 was always incontinent for bladder and bowel. Review of Resident #42's Comprehensive Care Plan, dated 01/27/2025, reflected the resident had bowel/bladder incontinence r/t: impaired mobility and one of the interventions was check as required for incontinence, wash, rinse, and dry perineum. Observation on 02/05/2025 at 9:02 AM revealed CNA D was about to transfer Resident #42 to her wheelchair through sit-to-stand. She said before she transfered the resident to her wheelchair, the resident would go to the restroom first for a bowel movement. She assisted the resident to a sitting position at the side of the resident's bed, put the sit-to-stand sling around the resident's torso, secured the sling to the sit-to-stand machine, and raised the resident to a standing position. CNA D rolled the resident to the restroom, pulled down the brief, and lowered the resident to the toilet seat. CNA D removed the sling and said she would wait for the resident. While she was waiting for the resident to be done, she removed her gloves, washed her hands, pulled a pair of gloves from the left pocket of her scrub top, and put on the gloves. She prepared some wipes on the sink covered with paper towels. When the resident was done with the bowel movement, CNA D put back the sling and raised the resident. She cleaned the bottom of the resident. After cleaning the resident's bottom, she removed her gloves, and put on a new pair of gloves. CNA D then cleaned the perineal area from back to front. She did it three times. After cleaning the perineal area, she pulled the resident's brief and pants back up, rolled the sit-to-stand machine out of the restroom, and lowered the resident to her wheelchair. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with CNA D on 02/05/2025 at 9:29 AM revealed CNA D demonstrated the manner she cleaned Resident #42's perineal area. She said she started on the sides and then the middle. When asked how she cleaned the middle of the perineal area, she demonstrated wiping the middle from back to front. She said it was because of the position of the resident that was why she cleaned the resident's perineal area that way. She said she still should had cleaned the resident's front part from front to back regardless of the position of the resident. She said the wiping should always be from front to back to prevent urinary tract infection. She said she should be mindful of how she does incontinent care because the resident would be at risk for infection. In an interview with the DON on 02/06/2025 at 8:07 AM, the DON stated the cleaning the perineal area should be from front to back to prevent cross contamination and probable infection. She said the procedure did not change with regards to the position of the resident. She said cleaning the perineal area was front to back whether the resident was in the bed, sitting in the toilet seat, sitting in a commode, or standing up. She said the gloves should not be placed in their pockets because, basically, we did not know how dirty their pockets were and then they would use the gloves from the pockets to clean the residents. She said the expectation was for the staff to focus on the prevention of infection and not their convenience. She said she would do an in-service about incontinent care and said the expectation was for them to practice the right procedure of incontinent care. In an interview with the ADON on 02/06/2025 at 9:41 AM, the ADON stated the proper way of cleaning the resident's perineal area would be always front to back to avoid transfer of germs from the bottom to the front part of the resident. He said the purpose of which was to prevent infection. He said the expectation was for the staff to do incontinent care the right way which was cleaning the front part from front to back. He said they would do an in-service pertaining to incontinent care focusing on proper cleaning of the front part of the residents. In an interview with the Administrator on 02/06/2025 at 10:07 AM, the Administrator stated improper incontinent care could cause infection and the expectation was for the staff to do the right procedure. He said he would collaborate with the DON on how to deal with the issue. Record review of facility policy, Perineal Care Policy/Procedure - Nursing Clinical revised 07/2021 revealed Policy . 3. Prevent irritation or infection . Procedures . NOTE: The basic infection control-concept for pericare is to wash from the cleanest area to the dirtiest area.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record review, the facility failed to ensure that one (Resident #59) of five residents was provided medications and pharmaceutical services, including the accurate administering of all drugs, to meet their needs. The facility failed to ensure MA did not leave Resident #59's medications inside the resident's room and failed to monitor the administration of the medications on 02/04/2025. This failure could place the residents at risk of chocking or not receiving medications as ordered by the physician. Findings included: Record review of Resident #59's Face Sheet, dated 02/05/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with hypertension (high blood pressure), gastro-esophageal reflux disease (stomach acid repeatedly flows back into the tube connecting your mouth and stomach), cerebral infarction (insufficient oxygen in the brain causing stroke). Record review of Resident #59's Quarterly MDS Assessment, dated 12/16/2024, reflected resident had a severe impairment in cognition with a BIMS score of 00. The Quarterly MDS Assessment also indicated the resident had cerebral infarction, hypertension, and gastro-esophageal reflux disease. Record review of Resident #59's Comprehensive Care Plan, dated 11/07/2024, reflected the resident had gastro-esophageal reflux disease, cerebral vascular disease, and hypertension and the interventions for the three medical issues were to give medications as ordered. Review of Resident #59's Clinical Assessment on 02/04/2025 reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment that the resident was competent to manage her own medications. Review of Resident #59's Physician Order, dated 04/04/2023, reflected Aspirin EC Tablet Delayed Release 81 MG (Aspirin). Give 1 tablet by mouth one time a day for CVA (cerebrovascular accident: stroke). Review of Resident #59's Physician Order, dated 04/04/2023, reflected Famotidine Oral Tablet 20 MG (Famotidine) Give 1 tablet by Mouth one time a day for GERD (gastro-esophageal reflux disease: stomach acid repeatedly flows back into the tube connecting your mouth and stomach). Review of Resident #59's Physician Order, dated 04/04/2023, reflected Nifedipine ER Oral Tablet Extended Release 24 Hour 30 MG (Nifedipine) Give 1 tablet by mouth one time a day for HTN DO NOT CRUSH Hold for SBP<110 DBP<60 HR<60, Observation on 02/04/2025 at 10:38 AM revealed MA was observed exiting Resident #59's room and closing the door. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with Resident #59 on 02/04/2025 at 10:40 AM revealed the resident was sitting on a chair beside her bed. In front of the resident was her overbed table with a small plastic cup on top of it. Inside the plastic cup was a white, round pill. The resident she was going to take the medication in a minute. She said she already taken two out of three pills that was left by the staff. She said the staff would leave her medications with her and she would take. She said she told her what the medications were, but she could not remember them and all she could remember was how many. In an interview with the MA on 02/04/2025 at 10:48 AM, the MA stated she did leave Resident #59's medication with her because the resident wanted to take the medication every five minutes. She said should have returned to the room and checked on the resident or stayed with the resident until the resident had taken all the medications. She said the pills should not be left with the resident because the resident might not take them, throw them, or choke while taking them and no one would know. She said she left three pills with the resident, her aspirin, famotidine, and her blood pressure medication. In an interview with the DON on 02/06/2025 at 8:07 AM, the DON stated staff should never leave the medications with the resident for the residents to take later. She said the staff must wait for the residents to be done with their medications before leaving the room. She said the resident might choke while taking the medications and no one would know. She said the resident might not take the medications or hide the pills to avoid taking them. She said the residents could also hoard the medications and take them altogether that could cause an overdose. The DON said the expectation was for the staff not to leave the room until the residents were done taking the medications or if the residents were still not ready to take the medication, just take the medications with them and come back later. She said she would do an in-service pertaining to not leaving the medications with a resident. In an interview with the ADON on 02/06/2025 at 9:41 AM, the ADON stated medications were not left with the residents. He said the staff administering the medications should stay with the resident until the resident was done taking the medications. He said the resident might not take them or someone else might, like another resident or a visitor. He said the resident might aspirate while taking the medications and nobody was with him. He said he would coordinate with the DON to do an in-service about not leaving the medications with the residents. In an interview with the Administrator on 02/026/2025 at 10:07 AM, the Administrator stated staff should not leave medications unattended because of the risk of the resident not taking them or the pills not taken on time. He said he would coordinate with the DON on how to go forward to prevent untoward outcomes of leaving the medications with a resident. Record review of facility policy, Medication Administration Policy/Procedure - Nursing Services revised 07/2020 revealed POLICY: It is the policy of this facility that medications shall be administered as prescribed by the attending physician . PROCEDURES . 4. Identification of the resident must be made prior to administering medication to the resident . 5. Medications may not be set up in advance and scheduled medications must be administered within facility time frame.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for three (Resident #42, Resident #45, and Resident #58) of eight residents reviewed for Infection Control. 1. The facility failed to ensure CNA B performed hand hygiene, changed her gloves, and did not put the gloves on her pocket while providing incontinent care to Resident #58 on 02/04/2025. 2. The facility failed to ensure CNA B and CNA C changed their gloves and performed hand hygiene while providing incontinent care to Resident #45 on 02/04/2025. 3. The facility failed to ensure CNA D changed her gloves and performed hand hygiene while providing incontinent care to Resident #42 on 02/05/2025. These failures could place residents at risk of cross-contamination and development of infections. Findings included: 1. Record review of Resident #58's Face Sheet, dated 02/05/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. The resident was diagnosed with urinary tract infection. Record review of Resident #58's Quarterly MDS Assessment, dated 10/28/2024, reflected the resident had moderate impairment in cognition with a BIMS score of 08. The Quarterly MDS Assessment indicated the resident was always incontinent for bowel and bladder. Record review of Resident #58's Comprehensive Care Plan, dated 01/29/2025, reflected the resident had bowel/bladder incontinence and one of the interventions was to provide pericare after each incontinent episode. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/04/2025 at 9:46 AM revealed CNA B was about to do Resident #58's incontinent care. CNA B washed her hands and put on a pair of gloves. She prepared some wipes, a brief, and a plastic bag and put them on the resident's overbed table. She lowered the head of the bed and raised the bed. She unfastened the brief and pushed it between the resident's thighs. She removed her gloves, threw them on the plastic bag placed on the overbed table, and put on a new pair of gloves that she took from the left pocket of her scrub suit's top. She did not sanitize her hands before pulling the gloves from her pocket. She pulled some wipes and cleaned the resident perineal area (area between the thighs) using the front to back technique. She did it three times. After cleaning the perineal area, she assisted the resident to roll towards the left side and cleaned the resident's bottom. After cleaning the resident's bottom, CNA B took the new brief from the overbed table, put it under the resident, and fixed it. She did not change her gloves after cleaning the bottom of the resident and before touching the new brief. After fixing the brief, CNA B assisted the resident to roll back and fastened the brief on both sides. CNA B took off her gloves, threw them in the trash bag, and washed her hands. 2. Record review of Resident #45's Face Sheet, dated 02/05/2025, reflected an [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with muscle weakness and need for assistance with personal care. Record review of Resident #45's Comprehensive MDS Assessment, dated 11/01/2024, reflected the resident had a severe impairment in cognition with a BIMS score of 02. Comprehensive MDS Assessment indicated the resident was always incontinent for bowel and bladder. Record review of Resident #45's Comprehensive Care Plan, dated 01/13/2025, reflected the resident had bowel/bladder incontinence and one of the interventions was provide pericare (cleaning the private areas of the resident) after each incontinent episode. Observation on 02/04/2025 at 1:22 PM revealed CNA B and CNA C were about to do Resident #45's incontinent care. Both staff washed their hands and put on a pair of gloves. CNA B went to the resident's left side, while CNA C went to the resident's right side. CNA B unfastened the brief and pushed it between the resident's thighs. CNA B removed her gloves, pulled some gloves from her scrub suits' left pocket, and put on the gloves. CNA B pulled some wipes placed on the resident's side and cleaned the resident's perineal area. CNA B removed her gloves, pulled some gloves from her left pocket, and put on the gloves. After CNA B cleaned the perineal area, both CNAs assisted the resident to roll to his right side and CNA B cleaned the resident's bottom. After cleaning the resident's bottom, CNA B pulled the brief and threw it on the trash can. After CNA B threw the soiled brief, it was observed that the resident was still having a bowel movement. CNA B continued to clean the resident's bottom and placed the used wipes on the padding. After cleaning the resident's bottom, again, CNA B removed her gloves, went to the bathroom, took a box of gloves, placed some gloves in her pocket, and put on a pair of gloves. CNA B instructed CNA C to get the resident's brief on top of the resident's drawer. CNA C gave the brief to CNA B. CNA B placed a new padding on top of the rolled soiled padding, put the new brief on top of the new padding, and fixed them. Both CNAs rolled the resident to the other side. CNA C took the soiled padding with soiled wipes in it, put it on a plastic bag, and helped in fixing the brief. They rolled back the resident and fastened the brief. CNA C did not change her gloves after putting the soiled padding on a plastic bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with CNA B on 02/04/2025 at 1:42 PM, CNA B stated she did change her gloves when she did Resident #58 and Resident # 45's incontinent care but did not sanitize in between changing of gloves. She said hand hygiene should be done after removing the gloves to make sure the hands were not soiled before touching the new gloves. She said gloves should also be changed before touching the new brief to prevent the new brief from being soiled. She said gloves should not be placed in the pockets because she used her pockets for something else, like for her cellphone, her car keys, and others. She said she would be mindful next time not to put the gloves in her pocket, to change gloves after cleaning the residents' bottom, and to do hand hygiene when she changed her gloves. She said not sanitizing the hands when the gloves were changed and not changing the gloves could cause infection. She said putting the gloves in the packet could also indirectly cause infection. In an interview with CNA C on 02/06/2025 at 9:47 AM, CNA C stated she realized she did not change her gloves after pulling the soiled padding that had soiled wipes in it. She said she should have changed her gloves, sanitized her hands, and put on a new pair of gloves. She said her gloves were basically soiled when she assisted in fixing the brief. She said not changing the gloves could cause infection like urinary tract infection. 3. Review of Resident #42's Face Sheet, dated 02/05/2025, reflected the resident was a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with acute kidney failure. Review of Resident #42's Comprehensive MDS Assessment, dated 01/22/2025, reflected the resident was cognitively intact with a BIMS score of 14. The Comprehensive MDS Assessment indicated Resident #42 was always incontinent for bladder and bowel. Review of Resident #42's Comprehensive Care Plan, dated 01/27/2025, reflected the resident had bowel/bladder incontinence r/t: impaired mobility and one of the interventions was check as required for incontinence, wash, rinse, and dry perineum. Observation on 02/05/2025 at 9:02 AM revealed CNA D was about to transfer Resident #42's to her wheelchair through sit-to-stand. She said before she transfered the resident to her wheelchair, the resident would go to the restroom first for a bowel movement. She assisted the resident to a sitting position at the side of the resident's bed, put the sit-to-stand sling around the resident's torso, secured the sling to the sit-to-stand machine, and raised the resident to a standing position. CNA D rolled the resident to the restroom, pulled down the brief, and lowered the resident to the toilet seat. CNA D removed the sling and said she would wait for the resident. While she was waiting for the resident to be done, she removed her gloves, washed her hands, and put on a pair gloves. She put some paper towel on the sink and put some wipes and a brief on the paper towels. When the resident was done with the bowel movement, CNA D put back the sling around the resident, hooked it to the sit-to-stand machine, and raised the resident. She cleaned the bottom of the resident first. After cleaning the resident's bottom, she removed her gloves and put on a new pair of gloves. She did not sanitize her hands when she changed her gloves. CNA D then cleaned the perineal area. After cleaning the perineal area, she pulled the resident's brief and pants back up, rolled the sit-to-stand machine out of the restroom, and lowered the resident to her wheelchair. She did not change her gloves after cleaning the resident's perineal area and before pulling up the brief. (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	02/06/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with CNA D on 02/05/2025 at 9:29 AM revealed CNA D stated hands should be washed or sanitized when changing the gloves. She said gloves should be clean when touching the brief to prevent infection. She said the gloves should be changed after she cleaned the resident's perineal area and before touching the brief because the gloves that she used to clean the resident's perineal area were already soiled. She said she would be mindful the next time she does incontinent care to wash her hands and change her gloves during incontinent care. She said she had trainings for pericare but did not know why she forgot to wash her hands and change her gloves. In an interview with the DON on 02/06/2025 at 8:07 AM, the DON stated hand hygiene was the most effective way to prevent cross contamination and any kind of infection. She said the expectation was for the staff to sanitize their hands in between changing of gloves and change their gloves after touching anything soiled. She said, another expectation was for the staff to get their gloves from the boxes and not put them in their pockets. She said the pockets might be dirty that would render the gloves also dirty. She said she would do and in-service about hand hygiene, incontinent care, and not putting the gloves in their pockets. She said she would personally monitor the staff doing direct care. In an interview with the ADON on 02/06/2025 at 9:41 AM, the ADON stated putting the gloves in the pocket was a bad habit. He said the gloves, when placed in the pockets, could be considered soiled because the dirt from the pockets might cling to the gloves. He said hands should be sanitized every time the gloves were removed, and gloves should be changed after touching something soiled to prevent cross contamination and development of infection. He said they would he would remind the staff to change their gloves from dirty to clen, sanitize in between changing of gloves, and not to put their gloves in their pockets. He said they would also do an in-service about hand hygiene, pericare, and not to put the gloves in the pockets of their scrub suits. In an interview with the Administrator on 02/026/2025 at 10:07 AM, the Administrator stated the staff should change their gloves and sanitize their hands to prevent infection. He said they should not put the gloves in their pockets. He said the expectation was for the staff to follow the policy and procedures pertaining to incontinent care and infection control. He said he would coordinate with the DON on how to handle the issue about infection control and hand hygiene. Record review of facility policy, Perineal Care Policy/Procedure - Nursing Clinical revised 07/2021 revealed Policy . 3. Prevent irritation or infection. Record review of facility policy, Hand Hygiene Infection Prevention and Control Program 2009 revealed Policy: This facility considers hand hygiene the primary means to prevent the spread of infections . 4. Use an alcohol-based hand rub . f. Before donning sterile gloves . h. Before moving from a contaminated body site to a clean body site during resident care . j. After contact with blood or bodily fluids . k. After handling used dressings, contaminated equipment, etc. m. After removing gloves . Applying and removing gloves . 1. Perform hand hygiene before and after applying non-sterile gloves.