STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675611	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2023
NAME OF PROVIDER OR SUPPLIER The Villages of Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for one (Resident #99) of 5 residents reviewed for dignity. The facility failed to treat Resident #99 with dignity and promote enhancement of her quality of life when the resident was not provided a privacy bag for her catheter bag. This failure placed residents at risk of not having their right to a dignified existence maintained and a decline in their quality of life. Findings included: Review of Resident #99's Face Sheet dated 12/19/2023 reflected resident was an [AGE] year-old female admitted on [DATE]. One of her diagnoses was encounter for fitting and adjustment of urinary device. Review of Resident #99's Quarterly MDS assessment dated [DATE] reflected Resident #99 was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated resident had an indwelling catheter. Review of Resident #99's Comprehensive Care Plan dated 12/07/2023 reflected Resident #99 had an indwelling catheter and one of the interventions was provide catheter care every shift. Review of Resident #99's Physician Order dated 12/02/2023 indicated, POSITION PRIVACY BAG & TUBING BELOW THE LEVEL OF THE BLADDER. Observation on 12/19/2023 at 2:51 PM revealed Resident #99 was on her wheelchair resting. Resident #99 had a catheter bag hanging under the wheelchair seat. The catheter bag was observed visible upon entrance to the room. The catheter bag did not have a privacy bag. (continued on next page)

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.

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

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	12/21/2023

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN A on 11/20/2023 at 11:16 AM, LVN A acknowledged Resident #99's catheter bag did not have a privacy bag. LVN A said she changed the catheter bag and placed it inside a privacy bag. She said without the privacy bag, the resident might be embarrassed. She said she reminded the CNA assigned on the hall to make sure to place a privacy bag when the resident was transferred to the wheelchair. Interview with CNA O on 12/20/2023 at 11:25 AM, CNA O stated she hung the catheter bag under the wheelchair and forgot to put a privacy bag on the catheter bag. She said there should be a privacy bag whether the resident was inside the room or outside the room to prevent embarrassment. Interview with the DON on 12/21/2023 at 8:25 AM, the DON stated the catheter bag should have been placed inside a privacy bag to avoid awkwardness. The DON said all the staff, including her, were responsible in providing dignity to the residents with catheter. The DON said the expectation was for the staff to make sure the catheter bag had a privacy bag when the resident was on the bed or in the wheelchair. She concluded that she would continually remind the staff the importance of catheter care through an in-service. Interview with the Administrator on 12/21/2023 at 8:49 AM, the Administrator stated he was not familiar with the procedure for catheter care but would expect the staff to do what was ordered and what was the best practice to prevent embarrassment because the catheter bag was exposed. Review of facility policy, Indwelling Urinary Catheter Care, Policy and Procedure rev. 01.2022 revealed Policy: It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and as needed (PRN) for soiling . Purpose: To promote hygiene, comfort, and decrease the risk of infection for a resident with an indwelling urinary catheter . Procedure . 14. Cover the drainage bag with a privacy bag to maintain dignity.

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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 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** 45055 Based on observation, interview, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for four (Resident #97, #49, and #60) of eight residents reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Residents #97, #49 and #60's rooms was in a position that was accessible to the residents. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency, or cause resident's unnecessary injuries. Findings included: Resident #97 Review of Resident #97's Face Sheet dated 12/21/2023 reflected resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included muscle weakness, lack of coordination, and cognitive communication deficit. Review of Resident #97's Quarterly MDS assessment dated [DATE] reflected Resident #97 had a moderate cognitive impairment with a BIMS score of 09. Resident #97 required extensive assistance for bed mobility, transfer, dressing, toilet use, and personal hygiene. Review of Resident #97's Comprehensive Care Plan dated 11/18/2023 reflected Resident #97 was at risk for fall related to generalized weakness and one of the interventions was to ensure the call light was within reach. The Comprehensive Care Plan also indicated the resident had an actual fall on 12/03/2023 due to poor balance and poor comprehension. Observation and interview with Resident #97 on 12/19/2023 starting at 09:12 AM revealed resident was on his bed finishing breakfast. Resident #97's call light was noted hanging on the right side of the bed with the call button lower than the bed. When asked where his call light was, Resident #97 replied his call light was usually on the side of his bed. Resident #97 started to search for his call light using his right hand but was not able to find it. Resident #97 raised his upper body, twisted to the right, and continued to search for his call light using his left hand. Resident #97 finally found the cord of the call light and pulled the cord to get hold of the call light button. Resident #97 sighed and said it took him two minutes to find his call light. Resident #97 continued it was not easy to look for his call light and the staff should place it where he could reach it. Resident #49 Review of Resident #49's Face Sheet dated 12/19/2023 reflected resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included low back pain, unsteadiness of feet, and muscle weakness. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #49's Quarterly MDS assessment dated [DATE] reflected Resident #49 was cognitively intact with a BIMS score of 15. Resident #49 required extensive assistance for bed mobility, transfer, dressing, toilet use, and personal hygiene. Review of Resident #49's Comprehensive Care Plan dated 10/14/2023 reflected Resident #49 was at risk for fall related to unsteady gait and one of the interventions was to ensure the call light was within reach. Observation on 12/19/2023 at 11:30 AM revealed Resident #49's was sitting on a chair on the right side of the bed. Resident #49's call light was noted on top of the side table located on the left side of the bed. Observation and interview with CNA M on 12/19/2023 at 11:45 AM, CNA M acknowledged she forgot to put Resident #49's call light near the resident when she assisted the resident to transfer from bed to chair. CMA M stated call lights were important for the residents because they use the call lights to let the staff know they needed something. CMA M said she should have placed the call light on the chair because the resident needed to walk a long way just to get the call light if he needed something. CMA M continued the resident could fall in the process of trying to get the call light. CMA M put the call light with the resident after putting the resident to bed. Resident #60 Review of Resident #60's Face Sheet dated 12/21/2023 reflected resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included history of falling, unsteadiness of feet, and muscle weakness. Review of Resident #60's Quarterly MDS assessment dated [DATE] reflected Resident #60 was unable to complete the interview to determine the BIMS score. Resident #60 required extensive assistance for bed mobility, transfer, dressing, toilet use, and personal hygiene. Review of Resident #60's Comprehensive Care Plan dated 12/23/2023 reflected Resident #60 was at risk for falls related to Parkinson's disease and recent falls and one of the interventions was to ensure the call light was within reach. The Comprehensive Care Plan also indicated the resident had an actual fall on 11/26/2023. Observation on 12/20/2023 at 8:42 AM revealed Resident #60 was sitting on her wheelchair at the right side of the bed. Resident #60's call light was noted on the floor, the cord of the call light was behind her wheelchair, and the call button under the bed. Interview with Resident #60 on 12/20/2023 at 9:02 AM, Resident #60 stated she was doing fine. When asked where her call light was, Resident #60 shrugged her shoulders and said she could not see her call light. Observation on 12/20/2023 at 11:16 AM revealed Resident #60's call light was still on the floor under the bed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with LVN A on 12/20/2023 starting at 11:18 AM, LVN A stated the residents used their call lights to let the staff know they needed an assistance. LVN A said without the call lights, the staff would not know if the residents needed something, wanted to go to the bathroom, or was having any pain. LVN A added the residents might fall trying to get the call light or trying to get somebody to help them. LVN A went inside Resident #60's room, picked up the call light, and placed it on top of the bed. Observation and interview with CNA O on 12/20/2023 starting at 11:25 AM, CNA O stated the call lights were very important for the residents. The residents used their call lights to call the staff if they need to be changed, if they need a glass of water, or if they need the nurse for a pain pill. CNA O added if the residents did not have their call lights, their needs would not be addressed. CNA O went inside Resident #60's room and checked the call lights if it was still on the floor. Interview with the DON on 12/21/2023 at 8:25 AM, the DON said she just finished an in-service about call lights the week prior. The DON added the in-service was about clipping the call lights on the pillow or the blanket instead of coiling the cord of the call lights on the railings of the bed. The DON said the call lights were important for the residents. She said the residents used the call lights to call the staff if they needed assistance. The DON added the needs of the resident could be of any type, it could be for a glass of water, for a pain medication, if they needed to go to the restroom, or if they would like to go out of the room. She said if the call lights were not with the residents, the residents' needs would not be met. The DON said the expectation was for the staff would make sure the call lights were with the residents at all times. The DON concluded she would continually remind the staff to be diligent in making sure the call lights were within reach of the residents. Interview with the Administrator on 12/21/2023 at 8:49 AM, the Administrator stated the call lights should always be within the reach of the residents at all times. The Administrator said a lot could happen if the residents were not able to reach the call lights. The Administrator said the needs of the residents would not be addressed if they do not have their call lights. The Administrator said the expectation was to learn from this oversight. The Administrator said he would collaborate with the DON and ADON to make sure the call lights were being monitored. Record review of the facility's policy on Quality of Care, dated 07/2022, stated It is the policy of this facility that residents are given appropriated treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident in accordance with the written plan or care. Record review of facility's policy Call Light/Bell, Policy/Procedure - Nursing Clinical rev. 05/2007 revealed Policy: It is the policy of this facility to provide the resident a means of communication with nursing staff . Procedure . 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.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observations, interviews, and record review the facility failed to provide a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for areas in the facility for 11 (Residents #1, 10, 18, 23, 28, 34, 48, 53, 71, 72, and 75's) of 27 residents observed for a safe, clean, comfortable, and homelike environment. The facility failed to ensure that Residents #1, 10, 18, 23, 28, 34, 48, 53, 71, 72, and 75's rooms were cleaned, sanitized, and maintained. This failure could place residents at risk of infections and living in an uncomfortable environment leading to a decreased quality of life. Findings included: Observation of Residents' #53 and #71's room on 12/19/23 at 11:09 AM revealed the wall alongside Resident's bed had brownish stains and there were a small scrap marks on the wall. The air-condition unit had dark dirt stains on the top of the into and in between the vents. A shelf near the window had a brown circular stain. Observation of Resident #1's room on 12/19/23 at 11:13 AM revealed the air-condition unit had dark dirt stains on the top of the into and in between the vents. A wall in the room had large scrape marks. The resident's handrail had brownish stains near the top of the handrail. The bottom of the bedside table had white and brownish stains. A white shelf on the windowsill had brownish stains and black dirt particles all over the shelf. The back of the door to the entrance had a thick brownish dirt stain near the door handle. The toilet in the resident's bathroom had brownish stains circling the toilet. Observation of Resident #10's room on 12/19/23 at 11:16 AM revealed the bathroom door leading into the bathroom, had brownish and blackish dirt stains sprayed all over the door. One of the walls had blackish dirt particles and stains along the bottom portion of the wall and brownish stains along the bottom of the wall. Observation of Resident #23's room on 12/19/23 at 11:20 AM revealed the air-condition unit had dark dirt stains on the top of the into and in between the vents. A wall, located behind a trash can, had brownish stains sprayed along the bottom of the wall. Observation of Resident #34's room on 12/19/23 at 11:25 AM revealed a black mini fridge that had a thick white streaky film on the door. Inside the fridge had a grayish dirt stains and pieces of hair along the bottom. Cabinet doors had blackish and brownish stains sprayed all over the doors. The air-condition unit had dark dirt stains on the top of the into and in between the vents. Located near some boxes in the room was dark reddish dried up food stains on the floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident #48's room on 12/19/23 at 11:30 AM revealed dark food particles on the floor. The top of the bedside table had a white powdery substance on one corner, black dirt particles sprayed over, and there was smudge stains all over. The bottom of the bedside table had white and brownish stains. A wall near the entrance had brownish stains on the lower portion of the wall. Observation of Resident #28's room on 12/19/23 at 11:35 AM revealed a lower portion of the wall, near an outlet, had long black scrap marks. The air-condition unit had dark dirt stains on the top of the into and in between the vents. The corner of the bathroom floor, behind the toilet had black dirt stains in the corner of the floor. The floor under the sink had light brownish dirt stains and a white pipe under the sink had dark reddish dirt particles all over it. Observation of Resident #72's room on 12/19/23 at 11:40 AM revealed the top of the bedside table had a whitish stain and food particles. The bottom of the bedside table rails had dark dirt stains along the bottom rail. The air-condition unit had dark dirt stains on the top of the into and in between the vents. The resident's handrail on the bed had two dark brownish stains on the upper portion of the rail. Observation of Residents #18 and #75's room on 12/19/23 at 11:45 AM revealed a wall in the room had brownish stains and black scrape marks along the bottom of the wall. There was a large scrape marks on a wall near a wheelchair. The air-condition unit had dark dirt stains on the top of the into and in between the vents, and there was a dark brownish stain going down the front of the unit. The inside of the mini fridge had brownish and reddish stains along the bottom of the fridge. In an interview on 12/21/23 at 09:25 AM with CNA/Staffing Coordinator Y, she stated that staff were required to observe the resident's environment for cleanliness. She stated she checked the bed side tables, the mini fridges in the resident room, floors, and makes sure the bathroom was clean. She stated when she had observed any of the rooms dirty, she would notify housekeeping and the nurse on duty. She stated she was unsure who was responsible for cleaning out the mini fridge in the rooms, so she cleaned them. She stated she had observed holes in resident walls, and she notified her charge nurse, who would then submit a maintenance request in their Tier system. She stated the risk of not thoroughly cleaning the resident rooms was an infection control concern. In an interview on 12/21/23 at 09:21 AM with the DON, she stated leadership does not conduct any rounds to check rooms. She stated the ADON was required to observe residents and their rooms daily and one of the things that was observed was the cleanliness of the room. She stated that if the ADON observed any concerns, the ADON would notify someone in housekeeping to clean the room. She stated she may visit resident rooms at least 4 times a week and she reported any concerns to housekeeping and maintenance. She stated the mini fridges in resident rooms were normally organized by the resident, but they try to assist in keeping it clean. She stated the risk of not thoroughly cleaning rooms was infection control. Interview on 12/14/23 at 01:15 PM with the Administrator, he stated that he had spoken with the Maintenance Director and the Housekeeping Supervisor and was made aware of the concerns observed throughout the facility. He stated he would work with his leadership to in-service staff on who was responsible for cleaning specific areas in the facility and the frequency of the cleaning. He stated the concerns mentioned could be a dignity and infection control issue. (continued on next page)

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F 0584

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

In an interview on 12/21/23 at 01:42 PM with the Plant Manager, she stated housekeepers dust, mop, clean the toilets, sinks, disinfect and clean the whole room. AC units' vents are changed once a month and the fronts are cleaned once a month or as needed. She stated blinds and window sill are to be cleaned maybe once a week. She stated if they see spots or stains on the surfaces they are supposed use cleaning products to clean it. She stated all surfaces should be cleaned on an as needed basis. She stated the housekeeping supervisor checks rooms and area at least once a week. She stated if she sees issues, she writes it down and brings it to the attention of the Housekeeping Supervisor or Maintenance Director. She stated ceiling vents were supposed to be cleaned by maintenance, but housekeeping could also clean them. She stated if housekeeping sees that the vents need to be cleaned, they should notify the Housekeeping Supervisor and she will get with herself or someone from maintenance.

In an interview on 12/21/23 at 02:02 PM with the Housekeeping Supervisor, she stated housekeeping role was to basically clean the floors, walls, sinks, all surfaces of restrooms. Sweep, mop, dust, trash in each room. Housekeepers are supposed to let her know about stained privacy curtains, so she can have them replaced with clean ones. Three days per week, deep cleaned. Windows, window sills, blinds, touching everything the residents tough. Sub-kitchens they are to responsible for sweeping, mopping, counters, cabinets, cabinet doors, outside of the refrigerators and microwaves. She stated she does do audit checks of rooms and areas but she doesn't get to do it often because she is also overseeing maintenance issues and has other responsibilities, so she can't get to it as often or as regularly as she would like. She stated the condition of the rooms, after seeing photos the concerns in each area, was unacceptable. She stated she had new staff and they were still learning, but that was no excuse for the condition of the areas. She stated the cleanliness of the ceiling vents was the responsibility of the Plant Manager.

In an interview on 12/21/23 at 02:30 PM with Housekeeper S, she stated she had been at the facility for [AGE] years. She stated she mopped, dusted, dumped the trash, and put new lining. Check the bathroom and make sure its clean. She stated she wiped down the dressers, televisions, and the top of the window ledges. She stated on certain days they had to move the furniture and sweep and mop behind them but she could not recall the days. She stated she cleans the AC units' covers about three times a week. She stated not cleaning the rooms thoroughly could result in residents getting sick and it is not homelike.

In an interview on 12/21/23 at 12/21/23 03:18 PM with the Administrator, he stated they had just come out of a COVID outbreak and they had to concentrate on getting [NAME] 1 in shape, so they could move COVID positive residents there for care. He stated they also had staff who tested positive. He stated they have hired a person to solely be responsible for nourishment snacks for diabetic residents, as well as snacks for other residents. The staff person is also responsible for cleaning the refrigerators and microwaves of the sub-kitchens in the other buildings. He acknowledged they have areas to be addressed. He would not say what the impact to the residents could be, as a result of living in an unclean environment.

Review of the facility's policy on Environmental Services (November 2021) revealed To provide a clean, attractive, and safe environment for residents, visitors, and staff.

High Dust Wall Articles:

(continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Damp Dust the Doors and Wall the tops of items along the resident's room and restroom walls (door frames, picture frames, clocks, over bed lighting, door closures, etc.) that are at or above your shoulder height. Clean and Disinfect the Room Furnishings: A. Clean all furnishings in the resident's room including the bed rails, IV poles, doorknobs, wheelchairs, walkers, and all other high contact surfaces

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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** 45055 Based on observation, interview and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one of eight residents (Resident #6) reviewed for accident hazards and supervision. The facility failed to properly maintain wheelchairs for Residents #6. This failure could place residents at risk for discomfort, pain, and injuries. Findings include: Resident #6 Record review of Resident #6's face sheet reflected a [AGE] year-old male with an initial admitted [DATE] and a diagnosis of hemiplegia and hemiparesis affecting the left side if the Resident's body (Paralysis of left side of body), Type 2 Diabetes Mellitus (Elevated blood sugar), and cerebrovascular accident (stroke). Record review of Resident #6 Quarterly MDS assessment dated [DATE] reflected Resident #6 had a BIMS score of 02 (severe cognitive impairment). Resident #6 required a 3 person assist for all transfers. Record review of Resident #6's care plan updated on 08/23/23 reflected . Daily body checks . Needs moisturizer applied to skin. Do not massage over bony prominences. Observation of resident on 12/19/23 at 11:55 AM revealed Resident #6 was lying on his bed, he was unable to be interviewed due to his severe cognitive impairment. The Resident #6's wheelchair which was seen at the side of his bed. The wheelchair did not have a right arm rest cushion and the left arm rest cushion was torn, the black leather cover was falling off. In an interview and observation on 12/21/23 at 09:24 AM with CNA J. CNA J stated she was working at the facility for 8 months and she provides care to Resident #6. CNA stated resident recently had a hospitalization and he came back with his current wheelchair. Surveyor took CNA J to the Resident #6's room, CNA J identified Resident #6's wheelchair, CNA J stated she did not notice the missing arm rest cushion on the right and torn left arm rest cushion on the wheelchair until then. She stated the resident used his wheelchair daily. C NA J stated Resident #6 was severely cognitively impaired to notify the staff about any concerns about his wheelchair and he needed assistance with all of his ADLs. CNA stated these damages to the wheelchair can cause skin tears to the resident. CNA stated she was responsible to report the wheelchair damage to the charge nurse and report to therapy department who was responsible to maintain the wheelchair. CNA stated she did not report this to anybody since she did not notice the damage until the surveyor pointed this out. (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 12/21/23 at 09:34 AM with the LVN/charge nurse D. The LVN stated she was working at the facility for 6 months. The LVN stated she was not aware of the missing and torn arm rest cushion to Resident #6. The LVN stated the CNA who provide care to the resident was expected to report the damage to LVN and CNA was responsible to note in the resident's chart. The LVN stated she was supposed to document this in the progress note and TELS system, maintenance should look at it if this was reported through TELS. The LVN stated the maintenance or therapy department were responsible to maintain the wheelchair if they knew about it. The LVN stated the above-mentioned damages to the wheelchair could potentially cause fall, pressure sore, scratches to the resident's arm. In an interview on 12/21/23 at 09:54 AM with the DON, she stated she was working at the facility for 8 years. The DON stated she was not aware of the damage to Resident #6's wheelchair harm rest. The DON stated Resident #6 was cognitively impaired and he was not capable of communicating to the facility staff about the damage to his wheelchair. The DON stated the damages to Resident #6's wheelchair could potentially lead to fall risk and skin abrasion. The DON stated all staff providing service to Resident #6 were expected to report the damage to the therapy department, therapy was responsible to maintain or replace wheelchairs. The DON stated the facility did not have a specific policy related to wheelchair damage reporting and maintenance. In an interview on 12/21/23 at 11:10 AM with Occupational Therapist M. OT M stated she was not aware of Resident #6's wheelchair arm rest damages, and it was therapy's responsibility to replace damaged or missing wheelchair arm rest, if this issue was observed by a therapist or reported to the therapy department. Occupational Therapist stated Resident #6's wheelchair issue was not reported to the Therapy department. Therapist stated the above-mentioned damages to Resident #6's wheelchair could potentially cause skin tear to resident's arms. In an interview on 12/21/23 at 11:20 AM with the ADON, he stated he just learned from the DON about the Resident #6's one wheelchair arm rest cushion was missing and other one was torn. The ADON stated he could not comment on the potential impact on the Resident #6 due to the above said damages to his wheelchair because they have never encountered such a problem in the past with any resident in the facility. The ADON stated he did not know who was responsible to maintain or repair the damaged wheelchair, usually they report to Therapy department who would do the maintenance of wheelchairs. In an interview on 12/21/23 at 11:31 PM, with the Maintenance Director. She stated the maintenance department address wheelchair repairs and maintenance if the issue was reported by the LVN or any staff through the TELS system. The Maintenance Director stated she was not aware of Resident #6's wheelchair right armrest cushion was missing and left arm rest cushion was torn, this was not reported to TELS. In an interview on 12/21/23 at 03:10 PM with the Administrator, he stated the wheelchair maintenance and repairs were managed by either therapy department or maintenance. If the issue was reported via TELS system, the maintenance will take care of it. If the issue was reported to therapy, they will do the maintenance. The Administrator stated he does not think the missing wheelchair arm rest cushion, or the torn arm rest cushion would cause an impact/risk on the resident.

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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 on observation, interview, and record review the facility failed to ensure a resident was incontinent of bladder received services and assistance to prevent urinary tract infections for one (Resident #99) of two residents reviewed for urinary incontinence. The facility failed to prevent Resident #99's indwelling urinary foley catheter device from contact with the floor. These failures could place the resident with indwelling urinary catheter devices at risk for the development of new or worsening urinary tract infections. Findings included: Review of Resident #99's Face Sheet dated 12/19/2023 reflected resident was an [AGE] year-old female admitted on [DATE]. One of her diagnoses was encounter for fitting and adjustment of urinary device. Review of Resident #99's Quarterly MDS assessment dated [DATE] reflected Resident #99 was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment indicated resident had an indwelling catheter. Review of Resident #99's Comprehensive Care Plan dated 12/07/2023 reflected Resident #99 had an indwelling catheter and one of the interventions was provide catheter care every shift. Review of Resident #99's Physician Order dated 12/02/2023 indicated, CHANGE FOLEY CATHETER MONTHLY ON 18th DAY OF EACH MONTH. REINSERT PRN FOR ACCIDENTAL REMOVAL, DISLODGEMENT, OBSTRUCTION OF URINE FLOW. Review of Resident #99's Physician Order dated 12/02/2023 indicated, POSITION PRIVACY BAG & TUBING BELOW THE LEVEL OF THE BLADDER. Observation on 12/19/2023 at 2:51 PM revealed Resident #99 was on her wheelchair resting. Resident #99 had a catheter bag hanging under the wheelchair seat. The catheter bag was observed visible upon entrance to the room. The end part of the catheter bag was noted touching the floor. Interview with LVN A on 12/20/2023 at 11:16 AM, LVN A stated the catheter bag should have been off the floor because it could cause infection. LVN A acknowledged Resident #99's catheter bag was touching the floor the day before. LVN A said she changed the catheter bag, placed it inside a privacy bag, and made sure it was off the floor. She said she reminded the CNA assigned on the hall to make sure that the catheter bag was off the floor when the resident was on the bed or on the wheelchair. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with CNA O on 12/20/2023 at 11:25 AM, CNA O stated she did not notice Resident's catheter bag was on the floor. CNA said she hung the catheter bag under the wheelchair but did not notice it was touching the floor. She stated that it was important to maintain a resident's indwelling foley catheter off the floor to prevent infection. Interview with the DON on 12/21/2023 at 8:25 AM, the DON stated the facility was using an anti-reflex catheter bag to prevent infection. The DON said the best practice still was the catheter bag was off the floor. The DON said all the staff, including her, were responsible in ensuring the catheter bag was off the floor. The DON said the expectation was for the staff to make sure the catheter bag was off the floor when the resident was on the bed or in the wheelchair. She concluded that she would continually remind the staff the importance of catheter care through an in-service. Interview with the Administrator on 12/21/2023 at 8:49 AM, the Administrator stated he was not familiar with the procedure for catheter care but would expect the staff to do what was ordered and what was the best practice to prevent infection. Review of facility policy, Indwelling Urinary Catheter Care, Policy and Procedure rev. 01.2022 revealed Policy: It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and as needed (PRN) for soiling . Purpose: To promote hygiene, comfort, and decrease the risk of infection for a resident with an indwelling urinary catheter . Procedure . 12. May secure the tubing with a securement device . 14. Cover the drainage bag with a privacy bag to maintain dignity.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interview, and record review the facility failed to ensure residents who are fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for one (Resident #2) of one resident reviewed for gastrostomy tube management. The facility failed to ensure Resident #2 had a continuous feeding through a G-tube (A tube directly inserted through the skin to the stomach to deliver nutrition) as per ordered. The facility failed to ensure LVN M had the enteral feeding supplies needed to change the feeding formmula of Resident #2. The facility failed to ensure Resident #2 had a clear and complete order for the downtime. These failures could place residents who receive enteral feedings by G-tube at risk for infection, underfeeding or overfeeding. Findings include: Review of Resident #2's Face Sheet dated 12/19/2023 reflected resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included gastrostomy, and dysphagia. Review of Resident #2's Comprehensive MDS assessment dated [DATE] reflected Resident #2 was unable to complete the interview to determine the BIMS score. The Comprehensive MDS Assessment indicated one of Resident #2's primary medical conditions was malnutrition or risk for malnutrition. Review of Resident #2's Care Plan dated 11/08/2023 reflected resident had a swallowing problem related to holding food in mouth/choking during meals. Review of Resident #2's Physician Order dated 12/14/2023 indicated, every shift FORMULA: JEVITY 1.5 @ 45 ML/HR X 22 HOURS. WATER FLUSH @ 30 ML/HR X 22 HRS. Observation on 12/19/2023 at 9:04 AM revealed Resident #2 was on her bed sleeping. Resident had a feeding tube connected to a feeding formula bag. The feeding tube was also connected to the feeding port of the resident. The feeding formula was empty, and the feeding pump was off. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with LVN M on 12/19/2023 starting at 9:28 AM, LVN M stated the order for the resident's feeding tube was continuous. LVN M said she turned off the feeding pump at around 6:30 AM and said she have not changed the feeding formula because she was waiting for the tubing she needed for the feeding formula. LVN M said she already called central supply for the tubing. LVN M acknowledged there was a three hour gap from the last bag of feeding formula. LVN M said the risk for the feeding gap was underfeeding and malnourishment. She said if the order was continuous, there should have been no gap except for the downtime. LVN M added the order specified to administer the feeding formula for 22 hours but there was no mention about the downtime. LVN M checked the system and confirmed there was no order for the downtime. LVN M asked the DON what was the downtime, the DON replied whatever was written in the order would be the downtime for the feeding tube. LVN M said the risk for no order for downtime could be confusion because the nurses would not know when to stop the feeding and when to continue the feeding. She said another risk would be overfeeding, aspiration, and fluid overload. She added some nurse might do it on the morning or some would do it in the afternoon. LVN M called MD to request an order for the downtime. Review of Resident #2's Physician Order dated 12/19/2023 indicated, Jevity 1.5 at 45 ml/hr via g-tube continuous feeding via pump 22 hrs/day. Off at 6:30 am, On at 8:30 am. Interview with the DON on 12/21/2023 at 8:25 AM, the DON stated if the order was continuous, there should be no gap on the feeding except during the downtime. The DON said there should be an order for the downtime so there would be consistency on when to stop the feeding and when to continue the feeding. She said if there was a gap more than the downtime, it could cause underfeeding and undernourishment. The DON said she was responsible in monitoring if the resident with G-tube had a n order for downtime. She said the expectation was to follow the order diligently, if the order said continuous, there should be no gaps except for the downtime and the order should specifically say what time was the downtime. The DON said she would continually remind the staff to follow the order and procedure of tube feeding. Interview with the Administrator on 12/21/2023 at 8:49 AM, the Administrator stated he would let the clinician answer about the questions regarding tube feeding. The Administrator said whatever was right should be done to be sure to give the best care. Moving forward would coordinate with the clinicians to make sure the adequate time required for tube feeding was given and make sure it was clear when to stop the feeding and when to start it again. Record review of facility's policy Gastrostomy Tube Care and Management, Policy/Procedure revealed Policy: It is the policy of this facility to provide proper care . gastrostomy tubes. Record review of facility's policy Physician Orders, Pharmacy Services/Nursing Services rev. 07/2022 revealed Policy . It is the policy of this facility to accurately implement orders . 7. Orders . must include . B. Quantity or specific duration of therapy . C. Dosage and frequency .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observations, interviews, and record reviews, the facility failed to ensure that Residents, who needed respiratory care, was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for five (Resident #2, #23, #34, #41, and #99) of eight residents reviewed for respiratory care. The facility failed to ensure Resident #2 and #99's nebulizer mask was properly stored. The facility failed to ensure Resident #34 had a clear order for O2 administration. The facility failed to ensure Resident #23, and #41's tubing for their oxygen concentrators were changed weekly as scheduled. These failures could place the residents at risk for respiratory infection and not having their respiratory needs met. Findings included: Resident #2 Review of Resident #2's Face Sheet dated 12/19/2023 reflected resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included acute respiratory failure with hypoxia and asthma. Review of Resident #2's Comprehensive MDS assessment dated [DATE] reflected Resident #2 was unable to complete the interview to determine the BIMS score. Resident #2's primary medical conditions were asthma and respiratory failure. Review of Resident #2's Care Plan dated 11/08/2023 reflected resident had asthma and one of the interventions was give nebulizer treatments and oxygen therapy as ordered. Review of Resident #2's Physician order dated 12/14/2023 reflected, Budesonide 0. 5 MG/2ML Suspension. Give 2 ml by mouth two times a day related to acute respiratory failure with hypoxia; unspecified asthma. Nebulize and inhale 2 ml (0.5mg) 2 times a day. Review of Resident #2's Physician order dated 12/11/2023 reflected, Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 3 ml inhale orally every 4 hours as needed for SOB or Wheezing via nebulizer. Budesonide 0. 5 MG/2ML Suspension. Give 2 ml by mouth two times a day related to acute respiratory failure with hypoxia; unspecified asthma. Observation on 12/19/2023 at 9:04 AM revealed Resident #2 was on her bed, awake. Resident #2's nebulizer mask was noted inside the drawer and on top of an incontinent brief. The nebulizer mask was not bagged. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LVN M on 12/20/2023 at 11:38 AM, LVN M stated the breathing mask should have not been exposed nor touching anything because it could cause infections. LVN M said the mask should have been bagged when not in use. The breathing mask should have been cleaned and then placed in a storage bag to make sure it would be clean when the resident used it. LVN M said she already changed the mask and placed it on plastic bag. Resident #34 Review of Resident #34's Face Sheet dated 12/19/2023 reflected resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included acute respiratory failure with hypoxia, shortness of breath and pneumonitis due to inhalation of food and vomit. Review of Resident #34's Comprehensive MDS assessment dated [DATE] reflected Resident #34 had a moderate impairment in cognition with a BIMS score of 8. Resident #34's primary medical conditions were pneumonia and respiratory failure. Review of Resident #34's Care Plan dated 11/02/2023 reflected resident had oxygen therapy related to SOB and one of the interventions was to give medications as ordered by physician. Review of Resident #34's Physician Order dated 10/04/2023 reflected, O2 at _ L/MIN VIA _ every 12 hours as needed for SOB, RESPIRATORY DISTRESS, CYANOSIS, LABORED BREATHING. Review of Resident #34's Physician Order dated 10/04/2023 reflected, O2 AT _ L/MIN CONTINUOUS PER every shift for o2 saturation above 90%. Observation and interview with LVN A on 10/11/2023 starting at 11:21 AM, LVN A confirmed Resident #34 was utilizing oxygen supplement as needed. LVN A said resident had been on as needed basis for oxygen supplement for quite some time. LVNA was asked what the order for Resident #34 was for oxygen administration. LVN A said for Resident #34, it was on as needed basis. She turned on her laptop and saw the orders for continuous oxygen and as needed oxygen. She also acknowledged she overlooked the orders were incomplete. The orders did not specify rate of the oxygen administration and the route of the oxygen administration. LVN A said she would confirm the order and remedy the mistake about the order for Resident #34's oxygen supplement. LVN A said it was important to have an order for anything and it was equally important that the order was complete. If the order was not compete, it could result to confusion and the respiratory needs of the resident would not be met. LVN A said she would discontinue the incomplete orders and would place a proper as needed order for oxygen supplement. Resident #99 Review of Resident #99's Face Sheet dated 12/19/2023 reflected resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included acute respiratory failure with hypoxia, pneumonitis due to inhalation of food and vomit, and chronic obstructive pulmonary disease with exacerbation. Review of Resident #99's Quarterly MDS assessment dated [DATE] reflected Resident #99 was cognitively intact with a BIMS score of 15. Review of Resident #99's Comprehensive Care Plan dated 12/07/2023 reflected resident had COPD and one of the interventions was give nebulizer treatments and oxygen therapy as ordered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #99's Physician Order dated 12/03/2023 indicated, Albuterol Sulfate (2.5 MG/3ML) 0. 083% Nebulization solution. 0.083% mg inhale orally via nebulizer 2 times a day. Observation and interview with Resident #99 on 12/19/2023 at 2:51 PM. Resident #99 was on her wheelchair resting. Resident #99 stated she was on breathing treatment because of her respiratory issues. Resident #99 said she usually had her treatment in the morning and in the afternoon. She said the nurse would place a liquid solution on the nebulizer cup attached to mask. The mask would be placed on her face covering her nose and mouth. Resident #99 continued the nurse would take it off and would usually place the nebulizer machine and the nebulizer mask on the drawer of her side table. The nebulizer mask was noted inside the drawer of the side table. The mask was not bagged and was touching the top of the nebulizer machine. Interview with LVN A on 12/20/2023 at 11:16 AM, LVN A stated the mask being used for the breathing treatment must be always clean. A dirty breathing mask could cause infections and various respiratory issues. She said she already changed the mask and placed it in a plastic bag to keep it clean. Resident #23 Record review of Resident #23's face sheet dated 12/19/23 revealed the resident was a [AGE] year-old female that was admitted on [DATE]. Her relevant diagnosis included chronic obstructive pulmonary disease (lung disease), and asthma (trouble breathing). Record review of Resident #23's Quarterly MDS dated [DATE] revealed the resident had a BIM score of 4 (severe cognitive impairment). Record review of Resident #23's Orders dated 12/19/23 revealed Physician orders for Oxygen 2-4 LPM via nasal cannula to keep O2 greater than 90% as needed. Record review of Resident #23's Care Plan revised on 10/23/23 revealed 'Oxygen Settings: (2-4) O2 via nasal prongs/mask @ (Specify) L continuously. Observation on 12/19/23 at 11:22 AM of Resident #23's tubing on the oxygen concentrator revealed it was dated 12/7 and 12/10. Resident #41 Record review of Resident #41's face sheet dated 12/19/23 revealed the resident was an [AGE] year-old female that was admitted on [DATE]. Her relevant diagnosis included chronic obstructive pulmonary disease (lung disease), shortness of breath, and heart failure. Record review of Resident #41's Quarterly MDS dated [DATE] revealed the resident had a BIM score of 00 (severe cognitive impairment). Record review of Resident #41's Orders dated 12/19/23 revealed Physician orders for Change oxygen tubing (and humidifier) every night shift every Sunday. Observation on 12/19/23 at 11:42 AM of Resident #41's tubing on the oxygen concentrator revealed it was dated 12/05. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an Interview and Observation on 12/19/23 at 02:30 PM with LVN N, she stated she was the evening nurse for the hall of Resident #23 and Resident #41. She stated that both residents used oxygen concentrators and the tubing and humidifier are changed out every Sunday evening by the night nurse. She stated that nurses were required to check to ensure that this had been completed anytime they checked on the resident. She was shown the dates for Resident #23 tubing date of 12/7 and 12/10, and Resident #41's tube dated 12/05/23. She stated that both tubing should have been changed and she did not know why it was not observed prior to today. She stated the risk of the residents tubing not getting changed it infection control. Interview with the DON on 12/21/2023 at 8:25 AM, the DON stated the breathing mask and the nasal cannula should be bagged when not in use. The DON said it was the proper way to store the breathing mask and the nasal cannula. She said if those breathing apparatus were not bagged, exposed, or touching surfaces that were not sure clean, the oxygen administration could be compromised. The DON said, the orders should be complete, it should had specified what to administer, the duration, the dosage, the route, and the rationale for the said treatment. If the order was not complete, the staff would not be able to know how much to administer, when it should be administered, and how it should be administered. The DON said the staff, including her, were responsible in monitoring that the equipment used in oxygen therapy were bagged when not in use. She said the expectation was the breathing mask and the nasal cannula would be stored properly and the orders for oxygen administration was complete. She stated the tubing and the fluid in the humidifier should be changed weekly on Sunday nights by the night shift nurse. The DON said she would continually remind the staff to be diligent in making sure the procedures for respiratory care were followed. Interview with the Administrator on 12/21/2023 at 8:49 AM, the Administrator stated that in general, the breathing masks and the nasal cannula should be stored properly to prevent respiratory issues. The Administrator said the orders should be complete to give the staff a clear overview of what should be done in terms of oxygen administration. The Administrator said the expectation is for the staff to be diligent in order to provide the highest level of care. Record review of facility's policy, Oxygen Administration, Policy/Procedure - Nursing Services rev. 07/2022 revealed POLICY: It is the policy of this facility that oxygen therapy is administered by licensed nurse as ordered by the physician . PURPOSE: The purpose of the oxygen therapy is to provide sufficient oxygen . will include: 1. That oxygen is to be administered; 2. When and how often oxygen is to be administered; 3. The type of oxygen device to use (i.e., mask, nasal).

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 45055 Based interviews and record reviews, the facility failed to maintain the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week, for 5 days of the 6-month review period, reviewed for RN coverage. The facility failed to ensure the facility maintained the services of a registered nurse for at least 8 consecutive hours a day on Saturdays and Sundays for 5 days of the four months (July 2023 - December 2023) reviewed. This failure placed residents at risk of receiving higher levels of patient care. Findings included: Review of the facility provided time sheets for Registered Nurses (RN) for the review period from July 2023 to December 2023, revealed the facility did not have the required Registered Nurses coverage of at least 8 consecutive hours a day, for the following dates: 11/04/23: 3.4 hours recorded 11/25/23: 1.15 hours recorded 12/02/23: 1.18 hours recorded 12/09/23: 1.63 hours recorded 12/16/23: 2.47 hours recorded In an interview on 12/21/23 at 09:21 AM with the DON, she stated she that they had a CNA that created the Registered Nurses schedules for the weekend coverage. She stated she was not aware of any missed RN hours for the past year. She stated any time they appeared to have a shortage in RN coverage, she would come in and cover for them. She stated she had the dates she had covered for staff and would provide the dates. The DON later returned with the dates she had worked and none of them were the dates mentioned previously. She stated she thought they had sufficient coverage and she helped when needed so she was unsure of why days were short of RN coverage. She stated the risk of there being no RN coverage was not good because it was required. In an interview on 12/21/23 at 09:21 AM with CNA/Staffing Coordinator Y, she stated she had been doing this for 8 years. She stated she created the Registered Nurses schedules for the weekend coverage. She stated she had never had any concerns of RN coverage for the past year. She stated that whenever an RN calls out and there was no coverage, she contacts the DON who usually covers. She stated she had the dates the DON covered. The CNA never returned with the dates the DON had worked. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/21/23 at 01:15 PM with the Administrator, he stated he was unaware of any lapse in RN coverage on the weekends. He stated he did not have any shortage in registered nurse. He stated he would have to follow up with the DON to see what happened. He stated the risk of not having RN coverage on the weekend was that he only knew that it was a requirement. Review of the facility's policy on RN Coverage, undated, revealed Facilities are responsible for ensuring they have an RN providing services at least 8 consecutive hours a day, 7 days a week.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45055 Based on observation, interviews, and record reviews the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety for the facility's main kitchen and the sub-kitchen, located in the skilled nursing area, reviewed for labeling and dating, and kitchen sanitation. The facility failed to ensure food in the facility's refrigerator, was labeled and dated according to guidelines and in a sanitary manner. The facility failed to ensure expired food was disgarded. The facility failed to ensure that the refrigerator, in the sub-kitchen was clean, sanitized, and did not contain staff foods. The facility failed to ensure the kitchen equipment in the main kitchen and sub-kitchen was clean and sanitized. These failures could place residents at risk for cross contamination and other air-borne illnesses. Findings included: Observations on [DATE] from 08:40 AM to 08:55 AM in the facility's only kitchen revealed: o One gallon container of sweet relish, located in the walk-in refrigerator, in the main kitchen was dated , d+[DATE] use by ,d+[DATE]. o Three large white bins containing sugar, flour, and thickener, located in the main kitchen area had dried up food particles and blackish stains on the outside of the bins and between the opening and the lid of the bins. In an observation on [DATE] at 8:48 AM of the kitchen substation on the skilled Nursing floor, revealed the counters to be stained with dried brown liquids. There were dried brown stains in a drip pattern on the walls. The refrigerator had dried liquid stains inside on the bottom and on other shelves, as well as in the freezer. There was pint-sized carton of a supplement drink, which was undated, on the door of the refrigerator. The door of the refrigerator would not close. In an interview on [DATE] at 9:00 AM with CNA/Staffing Coordinator Y, she stated the kitchen substation was used to store snacks and supplemental drinks for the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on [DATE] at 08:32 AM in the sub-kitchen revealed a refrigerator, that was identified by CNA/Staffing Coordinator Y, for the residents in the kitchen area. The refrigerator contained a large blue lunch bag, a medium container of watermelon, which was undated, and medium container containing grapes, honey [NAME], and cantaloupes, which was undated, and two plastic bags of foods that contained miscellaneous food items. The bottom of the refrigerator included two trays that were located on the bottom, had large dark brownish stains in one corner of the area and the other areas had reddish and brownish stains. The shelves in the door had brownish and reddish stains. The freezer section of the refrigerator had reddish and brownish stains and the freezer shelf on the door had reddish and brownish stains. There was a 16-ounce bottle of green tea (verified belonging to staff) in the freezer. The Ice Machine had dark black and white dirt stains along the inside door of the machine and along the inside walls of the machine. The lid of the ice machine hinges had rust and brownish dirt [NAME] in the springs of the door hinges. In an Interview on [DATE] at 08:05 AM with the Dietary Manager, she stated she managed the main kitchen in the facility but not the substation on the nursing side. She was advised of the food that appeared expired based on the dating, and she stated that the item was not dated correctly, and the use by date should have been ,d+[DATE] instead of ,d+[DATE]. She stated one of the kitchen staff dated it incorrectly and it was corrected. She stated the large bins containing flour, sugar, and thickener, were dirty and she had to remind her staff to clean it daily because of its location being under the preparation table. She stated she had in-serviced staff to clean the outside of the bins daily. She stated they usually wait until the bins were empty before cleaning the inside of the bin. She stated that she constantly had to remind her staff and she was considering moving the bins to an area where there was less traffic to avoid it from getting dirty so easily. She stated the risk of the concerns not being addressed could result in food-borne illnesses. In an interview on [DATE] 09:26 AM with CNA/Staffing Coordinator Y, she stated housekeeping was responsible for keeping the countertops, walls, floors, and sinks clean. She stated she thought the dietary department was responsible for keeping the refrigerator clean, but she was not for sure. She stated she was not sure who was responsible for keeping the rolling carts clean; however, whenever she would see something, she would wipe it down herself. In an interview on [DATE] at 12:54 AM with LVN N, she stated if nursing staff open a container in the refrigerator, they should either write the date they opened it, or they should pour the rest of the contents down the drain. She stated the dietary department staff were responsible to keeping the refrigerators, microwaves, and dietary carts clean. She stated if the refrigerator and microwave were not clean, it could cause cross contamination and make the residents sick. She stated she had previously kept the ice chest next to the nurses station and had recently moved the refrigerator over, to make room for the cart which held the ice chest, inside the Nourishment room. She stated she did that, so residents and visitors had to request ice from staff, in order to control risk of contamination. She stated if she saw residents or visitors accessing the ice chest, she would dump the ice and disinfect the chest before filling it with fresh ice. (continued on next page)

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	675611	A. Building B. Wing	12/21/2023

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 02:02 PM with the Housekeeping Supervisor, she stated they were responsible for sweeping, mopping, counters, cabinets, cabinet doors, outside of the refrigerators and microwaves in the sub-kitchen. She stated she does do audit checks of rooms and areas, but she doesn't get to do it often because she was also overseeing maintenance issues and has other responsibilities, so she can't get to it as often or as regularly as she would like. She stated the condition of the rooms, after seeing photos the concerns in each area, was unacceptable. She stated she had new staff, and they were still learning, but that was no excuse for the condition of the areas. She stated she was going to get with [NAME] about who would be doing what and scheduling. In an interview on [DATE] at [DATE] at 03:18 PM with the Administrator, he stated they have hired a person to solely be responsible for nourishment snacks for diabetic residents, as well as snacks for other residents. The staff person was also responsible for cleaning the refrigerators and microwaves of the sub-kitchens in the other buildings. He acknowledged they have areas to be addressed. He would not say what the impact to the residents could be, as a result of living in an unclean environment. Record Review of the Facility's policy on Food Storage and Supplies dated 2012, revealed All facility storage areas will be maintained in an orderly manner that preserves the condition of food and supplies. Air-tight containers or bags are used for all opened packages of food. All containers are accurately labeled with the item and date opened. Review of the U.S. Food and Drug Administration (FDA) Code (2022) revealed, PACKAGED FOOD shall be labeled as specified in LAW, including 21 CFR 101 FOOD Labeling, 9 CFR 317 Labeling, Marking Devices, and Containers, and 9 CFR 381 Subpart N Labeling and Containers, and as specified under S ,d+[DATE].18. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts ,d+[DATE] - ,d+[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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743 Based on observation, interview and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practice for one (Resident #99) of 5 residents reviewed for pressure ulcers. The facility failed to document wound care treatments and pain assessment during wound care treatments. This failure could place resident at risks for incomplete medical records. Findings included: Resident #99 Review of Resident #99's Face Sheet dated 12/19/2023 reflected resident was an [AGE] year-old female admitted on [DATE]. One of her diagnoses was pressure ulcer of sacral region with unspecified stage. Review of Resident #99's Quarterly MDS assessment dated [DATE] reflected Resident #99 was cognitively intact with a BIMS score of 15. The Quarterly MDS Assessment also indicated resident had a pressure ulcer on the sacral region. Review of Resident #99's Comprehensive Care Plan dated 12/07/2023 reflected Resident #99 had pressure ulcer development to right buttock related to decreased physical activity and the goals was to show signs of healing and remain free from infection. Review of Resident #99's Physician Order dated 12/01/2023 indicated, Cleanse sacrum area with normal saline, apply calcium alginate and cover with dry dressing daily until resolved one time a day for wound healing. Review of Resident #99's Administrative Record Report dated 12/19/2023 reflected treatment to pressure ulcer to sacrum was not documented on 12/11/2023 and 12/18/2023. Review of Resident #99's Administrative Record Report dated 12/19/2023 reflected pressure ulcer to sacrum was not assessed for pain before wound treatment on 12/11/2023 and 12/18/2023. Review of Resident #99's Administrative Record Report dated 12/19/2023 reflected pressure ulcer to sacrum was not assessed for pain during wound treatment on 12/11/2023 and 12/18/2023. Review of Resident #99's Administrative Record Report dated 12/19/2023 reflected pressure ulcer to sacrum was not assessed for pain after wound treatment on 12/11/2023 and 12/18/2023. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation with LVN A on 12/20/2023 at 11:16 AM, LVN A stated Resident #99 had a pressure ulcer to right sacrum that was being treated daily with calcium alginate and covered with dry dressing. LVN A said whoever would do the wound care documented it on the system by placing their initials. LVN A pulled Resident #99's administration record and acknowledge there were no treatments done on 12/11/2023 and 12/18/2023. LVN A said she was not aware the treatments were not done on the said dates. LVN A added the facility had a wound care nurse that would do the wound care. LVN said if the wound care was done during those days it should have been documented on the system. If the treatments were not documented on the system, it meant the treatments were not done. LVN A said if the pressure ulcer were not treated, it could result to exacerbation of the wound, longer healing time, or development of infection. Interview with the DON on 12/21/2023 at 8:25 AM, the DON stated any wound with an order of daily treatment should have been treated every day. The DON said daily treatment could help the wound to heal appropriately. The DON said if the pressure ulcer was not treated as ordered, it could result to worsening of the pressure ulcer which was no good for the resident. The DON the order for wound care was placed on the system so the staff would know what, when, and how to treat the wound. She said whoever would do the treatment must put their initial on the system as proof that treatments were done. If there were no initials for those days, it would reflect the wound care was not done. The DON said the expectation was to do the wound care as ordered. She said she would ensure the staff were doing the wound care as ordered. Interview with the Administrator on 12/21/2023 at 8:49 AM, the Administrator stated he was not familiar with the procedure for wound care but would expect the staff to do what was ordered and what was the best practice so the wound would heal. Review of facility's policy Wound Care, Policy/Procedure - Nursing Clinical rev. 05/2022 revealed Procedure . Document treatment given . as indicated.

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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 - Few	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 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 two (Dietary Manager and CNA M) of five staff observed for infection control. The facility failed to ensure that CNA M changed her gloves and perform hand hygiene while providing incontinence care to Resident #49. The facility failed to ensure the Dietary Manager was wearing a face mask while in the kitchen area preparing food, when the facility required all staff to wear a face mask as a result of a COVID outbreak in the building. These failures could place the residents at risk of cross-contamination and development of infection. Findings included: Review of Resident #49's Face Sheet dated 12/19/2023 reflected resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included chronic respiratory failure with hypercapnia and chronic obstructive pulmonary disease with exacerbation. Review of Resident #49's Comprehensive MDS assessment dated [DATE] reflected that Resident #49 was cognitively intact with a BIMS score of 15. Resident #49 required extensive assist for bed mobility, transfer, dressing, toilet use, and personal hygiene. Review of Resident #49's Care Plan dated 10/14/2023 reflected resident had an ADL self-care performance related to weakness and confusion. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview with CNA M on 12/19/2023 at 11:30 revealed CNA M provided incontinent care for Resident #49. CNA M assisted resident to lie down on his bed from a chair. CNA M explained to resident what she was about to do. She lowered the head of the bed and then proceeded to wash her hands. After drying her hands, CNA M donned on a new pair of gloves. CNA M unfastened the tape on both sides of the soiled brief, rolled the front portion and pushed it down on the center. CNA M cleaned Resident #49's external reproductive system. CNA M took off her gloves and performed hand hygiene. CNA M put on a new pair of gloves. CNA M instructed and assisted Resident #49 to turn to resident's left side and proceeded to clean Resident #49's buttocks. CNA M pulled the soiled brief and threw it on the trash can. CNA M then went ahead and took the clean brief without changing her gloves or performing hand hygiene. She placed the new brief on resident's buttocks and instructed the resident to roll back. CNA M fastened the tape of the brief near her and instructed the resident to turn towards her. CNA M fixed the brief and instructed the resident to roll back. CNA M reached out and fastened the tape of the brief on the other side. CMA M pulled a thin blanket up to resident's chest. CNA M acknowledged she forgot to take off the gloves after she pulled the soiled brief. She said she failed to wash her hands and change her gloves before touching the clean brief. CNA M said it was important to wash hands and change gloves before touching the clean brief because the dirty gloves could cause contamination of the clean brief, and this could result to infection. Interview with the DON on 12/21/2023 at 8:25 AM, the DON stated she was made aware by CNA M about the infection control issue during incontinent care. The DON said the gloves should have been changed after cleaning the buttocks of the resident. Not changing the gloves could have resulted to infection and cross contamination. The DON added it was important to wash hands and change gloves during incontinent care because dirty gloves would contaminate the clean briefs. The DON explained if the resident wore a dirty brief, it could also cause skin irritations and infection like urinary tract infection. The DON said the expectation was the staff would remember to wash their hands and change their gloves when transitioning from a dirty area to a clean area. The DON concluded she would do an infection control in-service and would continually remind the staff to be diligent in making sure the procedures for infection control were followed. In an observation and interview on 12/19/23 at 08:45 AM with the Dietary Manager, she stated she managed the main kitchen in the facility. The DM was observed walking around the kitchen while food was being prepared for lunch, and she was not wearing a face mask, which was required by the facility. The DM stated that everyone in the kitchen was required to wear a face mask because of a recent outbreak of COVID in the building. She stated the risk of not wearing a face mask while food was being prepared could result in residents getting sick and its infection control. In an interview with the Administrator on 12/21/2023 at 8:49 AM, the Administrator stated that in general, the breathing masks and the nasal cannula should be clean to prevent infection. The Administrator said the gloves should be changed when cleaning the residents to prevent infection. The Administrator said that the expectation was for the staff to be diligent in order to provide the highest level of care. He stated because of so many residents recently getting COVID, all staff were required to wear a face mask at all times. He stated the staff in the kitchen were required to wear a mask in the kitchen while preparing food. He was advised that the DM was observed in the kitchen are, while food was being prepared and not wearing a face mask. He stated the risk of the DM not wearing a face mask while preparing food would not be good for the residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility's policy, Infection Control, Hand Hygiene, rev 10.2022 revealed Policy: It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards . Procedure . 1. Wash hands with soap and water . a. when hands are visibly soiled (e.g., blood, body fluids) .