STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675783	A. Building B. Wing	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Mountain View	2918 Duncanville Rd Dallas, TX 75211

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observations, interviews, and record review the facility failed to immediately inform the resident, consult with the resident's physician, and notify consistent with his or her authority, the resident's representative when there was a change in the resident's physical, mental, or psychosocial status for 2 (Residents #1 and #2) of 8 residents reviewed for MD notification. RN D failed ensure the MD was notified and document the notification of a missed dialysis appointment when Resident #1's dialysis transport was not available on 07/06/2024. RN D failed ensure the MD was notified and document the notification of a missed dialysis appointment when Resident #2's dialysis transport was not available on 07/06/2024. These failures could place all residents at risk for not having their changes of conditions addressed appropriately by their attending physician which could cause serious harm. Findings included: Record review of Resident #1's face Sheet, dated 07/12/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses included: Cerebral Infarction (disrupted blood flow to the brain), syncope and collapse (fainting or passing out), end-stage renal disease (kidneys cease functioning requiring long-term dialysis), type 2 diabetes mellitus with unspecified complications (low or high blood sugars), low vision right eye, category 1 (moderate visual impairment), blindness left eye category 4 (visual acuity worse than 1/60 with light perception), and hyperlipidemia (elevated level of lipids in the blood). Record review of Resident #1's quarterly MDS Assessment, dated 03/18/2024, reflected a BIMS score of 11, which indicated a moderate cognitive impairment. She used a wheelchair and was independent for eating, toileting, dressing, and personal hygiene, and dependent for transfers. She received dialysis services. Record review of Resident #1's Care Plan dated 05/22/2018 - Present, reflected, Problem: [Resident #1] receives dialysis 3x a week (Tues, Thurs, Sat). Interventions: Monitor for increased complications from dialysis- report abn's to MD. (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: 675783	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER The Villa at Mountain View		STREET ADDRESS, CITY, STATE, ZIP CODE 2918 Duncanville Rd Dallas, TX 75211	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Clinical Notes, dated 07/06/2024 at 1:39 PM and signed by RN D, reflected, [Resident #1] unable to go to dialysis due to transportation issue, called [Dialysis Center] to try and reschedule for later chair time on today, dialysis center full with no room for reschedules on today, resident will be put in for extra tr. on either 7/10/24 or 7/12/24, dialysis center to call facility on Monday 7/8/24 with date for extra treatment. A note dated 07/12/2024 at 10:50 AM, and signed but the ADON, reflected, Call placed to [Dialysis Center] and spoke with [Nurse] who stated that additional dialysis treatment is not needed as resident left at her dry weight and was stable. Addendum added at 11:08 AM and signed by the ADON, reflected, [MD] made aware, and no new orders noted. Clinical Notes dated 07/12/2024 at 11:11 AM, signed by LVN E, reflected, Called to [Dialysis center] spoke with [Nurse] related to extra treatment that was to be scheduled for [Resident #1] due to missing on 7/6/24 was told that looked like it was over looked and is full for today 10:30am. Call placed to [MD] spoke with him related to resident missing dialysis on 7/6/24 and no extra treatment was scheduled for her on the 7/10 or 7/12 but resident received dialysis on 7/9 and 7/11 tolerated no acute distress noted voiced no concerns to nurse, notified ADMINISTRATOR and ADON. A note dated 07/12/2024 at 11:37 AM and signed by LVN E, reflected, Call to caregiver, was informed that she was aware of resident not going to dialysis on Sat. 7/6/24. notified Dialysis this am resident do not need a extra treatment her DRY weight. was good per ADON. Record review of Resident #1's Dialysis Communication Record dated 07/09/2024 and signed by LVN E reflected, pre dialysis weight of 77.3 kg and post dialysis weight of 76.4 kg and dated 07/09/2024 and signed by LVN E reflected, pre dialysis weight of 77 kg and post dialysis weight of 76.4 kg. Record review of Resident #2's face Sheet, dated 07/12/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses included: anxiety disorder (persistent worry that interferes with daily life), chronic kidney disease, unspecified (kidneys cannot filter blood as they should), essential hypertension (multi-factorial high blood pressure), hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease (kidney failure), syncope and collapse (fainting or passing out), acquired absence of left leg below knee, and acquired absence of right leg below knee. Record review of Resident #2's quarterly MDS Assessment, dated 04/15/2024, reflected a BIMS score of 15, which indicated she was cognitively intact. She used a wheelchair and required supervision for hygiene, toileting, and dressing and partial assist for bed to chair transfers. She received dialysis services. Record review of Resident #2's Care Plan dated 06/07/2022 - Present, reflected, Problem: [Resident #2] receives dialysis 3x a week, Tuesdays, Thursdays, Saturdays at 1pm. Behavioral Symptoms: [Resident #2] has other behavioral symptoms not directed toward others as evidenced by occasional refusal to attend dialysis treatments. Intervention: Staff to educate resident risks involved with refusal of dialysis. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: The Villa at Mountain View		STREET ADDRESS, CITY, STATE, ZIP CODE: 2918 Duncanville Rd Dallas, TX 75211	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Clinical Notes, dated 07/06/2024 at 1:40 PM and signed by RN D, reflected, [Resident #2] unable to go to dialysis due to transportation issue, called [Dialysis Center] to try and reschedule for later chair time on today, dialysis center full with no room for reschedules on today, resident will be put in for extra tr. on either 7/10/24 or 7/12/24, dialysis center to call facility on Monday 7/8/24 with date for extra treatment. Responsible party made aware, md made aware. A note dated 07/12/2024 at 10:45 AM, and signed but the ADON, reflected, Call placed to [Dialysis Center] spoke with nurse [nurse] resident actually achieved her dry weight on 7/11/24 and there is no need for additional treatment. Addendum added at 11:07 AM and signed by the ADON, reflected, [MD] made aware no new orders noted. Record review of Resident #2's Dialysis Communication Record dated 07/09/2024 and signed by LVN L reflected, pre dialysis weight of 80.3 kg and post dialysis weight of 77.6 kg. and dated 07/11/2024 and signed by LVN L reflected, pre dialysis weight of 77.6 kg and post dialysis weight of 77.1 kg. In an interview on 07/12/2024 at 10:20 AM, Resident #1 said she attended dialysis on Tuesday, Thursday, and Saturday. She said she had lived in the facility for 5 years and only missed an appointment one time, on 07/06/2024. She said Receptionist B made a mistake and the contracted transporter did not come. She said when RN D tried to arrange for alternate transport, there were no appointments available. She said she felt fine and did not believe that missing dialysis had any negative impact on her. In an interview on 07/12/2024 at 10:25 AM, LVN E stated she did not know Resident #1 missed her dialysis appointment on 07/06/2024. She looked in the clinical notes and said RN D did note that the appointment was missed, and she tried to reschedule but there were none available appointments. She stated the note did not include a notification to the MD. She stated if a dialysis appointment was missed the MD should be notified, even if there was not change in condition. She stated Receptionist B organized the transports. She said the facility had their own van during the week but Resident #1 had dialysis on Saturdays, so they had a contracted service. She said she had no knowledge of Resident #1 ever missing dialysis prior to this. She said Resident #1 went to dialysis on 07/09/2024 and 07/11/2024 and no issues were noted but a missed dialysis appointment could cause fluid overload. In an interview on 07/12/2024 at 10:37 AM, Receptionist A stated Residents #1 and #2 went to dialysis on Saturdays. She said because the facility's van driver does not work on Saturday, they contract with a transport company to take Residents #1 and #2 to their dialysis appointments on Saturdays. She said all transports were scheduled and tracked by her or Receptionist C. She said the contracted transport company did call Receptionist C on 07/04/2024 to cancel their transport for Residents #1 and #2 on 07/06/2024. She stated there was some misunderstanding and alternate dialysis transport arrangements were not made for Residents #1 and #2 for 07/06/2024. She stated the BOM was the Manager on Duty last weekend and discovered this mistake. She stated the BOM called the ED who directed her to transport Residents #1 and #2 with the facility van but the facility van driver had the keys with him at home. She said by the time the facility van driver brought the keys to the facility, Resident #1 and #2's scheduled dialysis appointments were past. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Villa at Mountain View		STREET ADDRESS, CITY, STATE, ZIP CODE 2918 Duncanville Rd Dallas, TX 75211	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/12/2024 at 10:51 AM, the BOM stated she was the Manager on Duty on 07/06/2024. She said RN D informed her that Residents #1 and #2 did not have transportation to their dialysis appointments. She said the Receptionists made all the transport arrangements but there was no Receptionist at the facility on 07/06/2024. She said she called the contracted transport company who told her that they called Receptionist C on 07/04/2024 to inform her that they had to cancel transportation for Residents #1 and #2 on 07/06/2024 due to van maintenance issues. The BOM stated she called the ED who instructed her to transport Residents #1 and #2 with the facility van but the facility van driver had the keys at home with him. She stated by the time he brought the keys to the facility; the appointment time had passed, and dialysis had no other available appointments. She stated she did not call the MD to let them know of the missed dialysis appointments. She said she told the ED the appointments were missed, and the dialysis center would call back on 07/08/2024 to schedule follow up appointments for Residents #1 and #2. The BOM said she felt that there was a lack of communication, in that, Receptionist C did not follow up and reschedule transportation on 07/06/2024 for Residents #1 and #2 after the contractor cancelled the scheduled transport on 07/04/2024 for 07/06/2024. She stated the facility van keys should be at the facility and accessible to staff for backup transportation. She stated on 07/08/2024 the management team discussed both these issues in their stand-up meeting and the negative impacts missed dialysis appointments could have on resindets. She said residents who missed dialysis were at risk of fluid orverload and even death. In an interview on 07/12/2024 at 11:31 AM, the ADON stated he was informed of the missed dialysis appointments for Resident #1 and #2 on 07/08/2024 at the stand-up meeting. He stated the contract transport company called Receptionist C on 07/04/2024 to cancel their scheduled transport for 07/06/2024. He said Receptionist C did not inform anyone or make alternate arrangements for Resident #1 or #2's dialysis transport. The ADON said the facility failed to identify new transport for Residents #1 and #2 when regular transport was cancelled. He stated he did not see documentation that RN D notified the MD of the missed dialysis appointments. He stated he called the MD to inform him of the missed appointments and the MD reviewed dialysis communication sheets from 07/09/2024 and 07/11/2024 for both residents and had not connect. He stated the MD gave no new orders. The ADON said the facility's policy was to notify the MD for direction as a result of the missed dialysis treatment and document that direction. He stated residents were at [NAME] of fluid overload or even death if they missed dialysis appointments. In an interview on 07/12/2024 at 12:13 PM, CNA I stated he worked on 07/06/2024 and told RN D when he realized Resident #2's dialysis transport had not arrived. He stated he did not know what happened but Resident #2 did not get to her dialysis appointment during his shift. He said he had worked in the facility for seven years and did not recall any issues with dialysis transportation during that time. In a telephone interview on 07/12/2024 at 12:35 PM, the MD said neither he or his Physician Assistant were notified of Resident #1 and #2's missed dialysis treatments on 07/06/2024. He said he did expect to be notified because that was best practice, however both these residents were very stable, and he would not have done anything anyway. He stated if they had missed more than one dialysis treatment, he may have given direction for a change in treatment but not in this case. He said he reviewed the dialysis communication forms, for dialysis on 07/09/2024 and 07/11/2024, for both residents and had not concerns. He said there were no indications of any adverse effects to either resident as a result of the missed dialysis appointment on 07/06/2024. He said it was standard procedure to monitor the residents for signs and symptoms and report any changes to him at that point. He stated he never had any past concerns of the nursing staff not notifying him as needed. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/12/2024 at 1:15 PM, Resident #2 said she did miss her scheduled dialysis treatment on 07/06/2024 because there was no transportation. She said she did not experience any medical issues as a result of missing dialysis on that day. She said she went to dialysis on 07/09/2024 and 07/11/2024 and the dialysis center did not raise any concerns. She said she had never had any transportation issues at the facility in the past. In an interview on 07/12/2024 at 1:41 PM, CNA K stated she worked on 07/06/2024 and was aware of the transportation issues. She said Resident #1 was ready to go to dialysis, but transport did not come. She said she informed RN D, who was working on getting the facility van keys to transport Resident #1 to her dialysis appointment. She stated this did not work and Resident #1 missed her appointment. In an interview on 07/12/2024 at 1:54 PM, Receptionist C stated the contracted transport company used by the facility on Saturdays, for Residents #1 and #2 dialysis appointments did call her on 07/04/2024 and cancel transport for 07/06/2024. She misunderstood them and did not think they were referring to the 6th. She said she received a counseling from the ED because she had not informed anyone of the cancellation or made alternate arrangements. She said it was the Receptionist's duty to ensure transportation was secured for all resident's appointments. In an interview on 07/12/2024 at 2:03 PM, RN D said both Residents #1 and #2 missed their dialysis appointments on 07/06/2024. She said when she found out that the scheduled transporter had cancelled on 07/04/2024, she tried to reschedule the dialysis appointments for the center, but they did not have any alternate times available. She said the BOM did try to get the faculty van keys to make the transport herself but that did not happen timely as the van driver had taken the facility van keys home. She stated she had worked at the facility for a year and never had a problem with transport for residents in the past. RN D said the ED did direct her to make notification to the family and MD but she did not. She said she had an issue with another resident at the same time and overlooked making the notifications. She said both residents #1 and #2 were very stable and she did monitor for signs and symptoms related to the missed dialysis appointment, and none were noted. She said she should have notified the MD about the missed appointments as he may have made recommendations of changed orders. She stated she received a counseling from the ED for not making the MD notification. She said residents could be at risk of fluid overload if they missed dialysis appointments. In an interview 07/12/2024 at 2:30 PM, the ED stated the contacted transport company called Receptionist C on 07/04/2024 to cancel transport for Residents #1 and #2 on 07/06/2024. She said Receptionist C did not communicate that to anyone which resulted in no transportation on 07/06/2024. She stated the BOM called her, and she instructed her to make the transport for Residents #1 and #2 with the facility van. She said the van driver had the van keys at home with him and by the time he brought them to the facility, the appointment time had lapsed. She stated RN D tried to reschedule the dialysis appointments but there were no other times available. She said she told RN D to notify the MD and family about the missed appointments. The ED said RN D did not notify the MD. She said RN D was counseled for this and Receptionist C was counseled for not arranging alternate transport when the company canceled. She said missed dialysis could result in fluid overload for the residents. Record review of the facility's Employee coaching and counseling record, dated 07/08/2024, and signed by the Executive Director, RN D received a coaching and reflected, [RN D] failed to notify and document missed dialysis appointments to family and physician. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's protocol titled, Following Dialysis Recommendations, dated August 2017, reflected, The Communities Director of Nursing Services and Regional Director of Dietary Services will establish and maintain communication with the dialysis centers to ensure continuity of care for all dialysis Residents. Record review of the facility's policy titled, Physician Notification, updated March 2019, reflected, .It is the responsibility of the nursing staff to observe the change, make an assessment, and notify the physician as indicated based on the assessment . The nurse will: Recognize the condition change, Monitor the Patient and continue to assess the condition and changes, Notify the physician, patient, and patient representative of any change in condition.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observations, interviews, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible for contaminated sharps disposal bins, attached to 2 (100 and 400 Hall) of 6 Nurse Medication Carts and 1 of 1 treatment carts reviewed for hazards. LVN F failed to ensure contaminated sharps in the sharps bin attached to the facility's only treatment cart, was below the full line. LVN G failed to ensure contaminated sharps in the sharps bin attached to the 400 Hall Nurse Medication Cart, was below the full line. LVN H failed to ensure contaminated sharps in the sharps bin attached to the 100 Hall Nurse Medication Cart, was below the full line. These failures placed residents at risk of being exposed to contaminated sharps and possible bloodborne pathogens. Findings included: An observation on 07/12/2024 at 10:17 AM, revealed the Medication Cart on 100 Hall parked facing outward to the hall and against the wall. The red insert in the sharps bin, attached to the cart, was above the full line. No staff were noted in the hall at the time of the observation, but one resident was observed moving past the cart in their wheelchair. An observation and interview on 07/12/2024 at 11:24 AM, revealed the 400 Hall Nurses' Medication Cart parked midway down the 400 Hall, against the wall, facing outward toward the hallway. The red insert in the sharps bin, attached to the cart, was above the full line. The facility's treatment cart was observed parked beside the 400 Hall Medication Cart, and the red insert in the sharps bin, attached to the cart, was above the full line. LVN F stated the treatment cart was hers and she was responsible to ensure the sharps bins was not filled past the fill line. She said when sharps were above the full line, it posed a hazard to both residents and staff as they could get stuck by a contaminated needle. LVN F said residents moved through the hall freely and had access to the full sharps bins. She stated the 400 Hall Medication Cart belonged to LVN G. In an interview on 07/12/2024 at 11:31 AM, the ADON said the facility only had one treatment cart and LVN F was responsible for it. He said there were a total of six Nurse Medication Carts, one for each Hall. He said the nursing staff were responsible to ensure the sharps bins were changed. He said when the sharps bins were overfilled, they posed a risk of harm to residents and staff as they did not close properly, and sharps could poke staff or residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/12/2024 at 11:56 AM, LVN G said the sharps bin on her cart, the 400 Hall Nurse Medication Cart was filled past the full line. She said she did not notice it but had since changed it. She said when the bins were past the full line, contaminated sharps could stick out of the bin and pose a [NAME] of sticking staff or residents. She said it was the nurse's responsibility to change the bins when they got full. In an interview on 07/12/2024 at 12:50 PM, LVN H said she was responsible for the Medication Cart on 100 Hall. She said the sharps bin had been filled pasted the full line earlier in the morning. She said the ADON asked her to change the bin about an hour ago because it was filled passed the full line with contaminated sharps. She said this posed a risk of harm to residents as they could get stuck with any sharps that may not be sticking out of the full bin. She said nurses were responsible to ensure the bins were changed when they became full. In an interview on 07/12/2024 at 2:30 PM, the Executive Director said she was not told about the full sharps bins. She said she expected nursing staff to ensure the bins were changed when they were full. She said the bins do not always close properly when sharps were filled above the full line, and this could be hazardous to both staff and residents. The facility's policy on accidents and hazards was requested on 07/12/2024 and a procedure guide was provided, titled, Accidents / Hazards, dated May 2016. Record review of the guide reflected and outline of the steps to be taken in the event of an accident and did not reflect the facility's role in preventing accidents or hazards. No other policy was received at the time of exit. Record Review of the facility's policy titled, Sharps Disposal, revised January 2012, reflected, .3. During use, containers for contaminated sharps will be handled as follows: a. Designated individuals will ensure that the containers are easily accessible to employees and located as close as feasible to the immediate area where sharps are used or can be reasonably anticipated to be found; b. Nursing staff will ensure that the containers are maintained in an upright position throughout use; and c. Designated individuals will be responsible for sealing and replacing containers when they are 75% to 80% full to protect employees from punctures and/or needlesticks when attempting to push sharps into the container.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observations, interviews and record review the facility failed to ensure residents who required dialysis received such services, consistent with professional standards of practice, and the comprehensive person-centered care plan for 2 (Residents #1 and #2) of 8 residents reviewed for dialysis services. The facility failed to ensure Residents #1 and #2 were provided transportation to their dialysis appointment on 07/06/2024 or make alternate arrangements. The facility did not arrange alternate transportation for Residents #1 and #2 when their regular transport gave notice of cancellation on 07/04/2024. These failures could place residents who receive dialysis at risk for fluid overload and associated health complications. Findings included: Record review of Resident #1's face Sheet, dated 07/12/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses included: Cerebral Infarction (disrupted blood flow to the brain), syncope and collapse (fainting or passing out), end-stage renal disease (kidneys cease functioning requiring long-term dialysis), type 2 diabetes mellitus with unspecified complications (low or high blood sugars), low vision right eye, category 1 (moderate visual impairment), blindness left eye category 4 (visual acuity worse than 1/60 with light perception), and hyperlipidemia (elevated level of lipids in the blood). Record review of Resident #1's quarterly MDS Assessment, dated 03/18/2024, reflected a BIMS score of 11, which indicated a moderate cognitive impairment. She used a wheelchair and was independent for eating, toileting, dressing, and personal hygiene, and dependent for transfers. She received dialysis services. Record review of Resident #1's Care Plan dated 05/22/2018 - Present, reflected, Problem: [Resident #1] receives dialysis 3x a week (Tues, Thurs, Sat). Interventions: Monitor for increased complications from dialysis- report abn's to MD. (continued on next page)

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F 0698

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Record review of Resident #1's Clinical Notes, dated 07/06/2024 at 1:39 PM and signed by RN D, reflected, [Resident #1] unable to go to dialysis due to transportation issue, called [Dialysis Center] to try and reschedule for later chair time on today, dialysis center full with no room for reschedules on today, resident will be put in for extra tr. on either 7/10/24 or 7/12/24, dialysis center to call facility on Monday 7/8/24 with date for extra treatment. A note dated 07/12/2024 at 10:50 AM, and signed but the ADON, reflected, Call placed to [Dialysis Center] and spoke with [Nurse] who stated that additional dialysis treatment is not needed as resident left at her dry weight and was stable. Addendum added at 11:08 AM and signed by the ADON, reflected, [MD] made aware, and no new orders noted. Clinical Notes dated 07/12/2024 at 11:11 AM, signed by LVN E, reflected, Called to [Dialysis center] spoke with [Nurse] related to extra treatment that was to be scheduled for [Resident #1] due to missing on 7/6/24 was told that looked like it was over looked and is full for today 10:30am. Call placed to [MD] spoke with him related to resident missing dialysis on 7/6/24 and no extra treatment was scheduled for her on the 7/10 or 7/12 but resident received dialysis on 7/9 and 7/11 tolerated no acute distress noted voiced no concerns to nurse, notified ADMINISTRATOR and ADON. A note dated 07/12/2024 at 11:37 AM and signed by LVN E, reflected, Call to caregiver, was informed that she was aware of resident not going to dialysis on Sat. 7/6/24. notified Dialysis this am resident do not need a extra treatment her DRY weight. was good per ADON.

Record review of Resident #1's Dialysis Communication Record, dated 07/09/2024 and signed by LVN E reflected, pre dialysis weight of 77.3 kg and post dialysis weight of 76.4 kg and dated 07/09/2024 and signed by LVN E reflected, pre dialysis weight of 77 kg and post dialysis weight of 76.4 kg.

Record review of Resident #2's face Sheet, dated 07/12/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Diagnoses included: anxiety disorder (persistent worry that interferes with daily life), chronic kidney disease, unspecified (kidneys cannot filter blood as they should), essential hypertension (multi-factorial high blood pressure), hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease (kidney failure), syncope and collapse (fainting or passing out), acquired absence of left leg below knee, and acquired absence of right leg below knee.

Record review of Resident #2's quarterly MDS Assessment, dated 04/15/2024, reflected a BIMS score of 15, which indicated she was cognitively intact. She used a wheelchair and required supervision for hygiene, toileting, and dressing and partial assist for bed to chair transfers. She received dialysis services.

Record review of Resident #2's Care Plan dated 06/07/2022 - Present, reflected, Problem: [Resident #2] receives dialysis 3x a week, Tuesdays, Thursdays, Saturdays at 1pm. Behavioral Symptoms: [Resident #2] has other behavioral symptoms not directed toward others as evidenced by occasional refusal to attend dialysis treatments. Intervention: Staff to educate resident risks involved with refusal of dialysis.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675783	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER: The Villa at Mountain View		STREET ADDRESS, CITY, STATE, ZIP CODE: 2918 Duncanville Rd Dallas, TX 75211	

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's Clinical Notes, dated 07/06/2024 at 1:40 PM and signed by RN D, reflected, [Resident #2] unable to go to dialysis due to transportation issue, called [Dialysis Center] to try and reschedule for later chair time on today, dialysis center full with no room for reschedules on today, resident will be put in for extra tr. on either 7/10/24 or 7/12/24, dialysis center to call facility on Monday 7/8/24 with date for extra treatment. Responsible party made aware, md made aware. A note dated 07/12/2024 at 10:45 AM, and signed but the ADON, reflected, Call placed to [Dialysis Center] spoke with nurse [nurse] resident actually achieved her dry weight on 7/11/24 and there is no need for additional treatment. Addendum added at 11:07 AM and signed by the ADON, reflected, [MD] made aware no new orders noted. Record review of Resident #2's Dialysis Communication Record, dated 07/09/2024 and signed by LVN L reflected, pre dialysis weight of 80.3 kg and post dialysis weight of 77.6 kg. and dated 07/11/2024 and signed by LVN L reflected, pre dialysis weight of 77.6 kg and post dialysis weight of 77.1 kg. In an interview on 07/12/2024 at 10:20 AM, Resident #1 said she attended dialysis on Tuesday, Thursday, and Saturday. She said she had lived in the facility for 5 years and only missed an appointment one time, on 07/06/2024. She said Receptionist B made a mistake and the contracted transporter did not come. She said when RN D tried to arrange for alternate transport, there were no appointments available. She said she felt fine and did not believe that missing dialysis had any negative impact on her. In an interview on 07/12/2024 at 10:25 AM, LVN E stated she did not know Resident #1 missed her dialysis appointment on 07/06/2024. She looked in the clinical notes and said RN D did note that the appointment was missed, and she tried to reschedule but there were no available appointments. She stated Receptionist B organized the transports. She said the facility had their own van during the week but Resident #1 had dialysis on Saturdays, so they had a contracted service. She said she had no knowledge of Resident #1 ever missing dialysis prior to this. She said Resident #1 went to dialysis on 07/09/2024 and 07/11/2024 and no issues were noted but a missed dialysis appointment could cause fluid overload. In an interview on 07/12/2024 at 10:37 AM, Receptionist A stated Residents #1 and #2 went to dialysis on Saturdays. She said because the facility's van driver does not work on Saturday, they contract with a transport company to take Residents #1 and #2 to their dialysis appointments on Saturdays. She said all transports were scheduled and tracked by her or Receptionist C. She said the contracted transport company did call Receptionist C on 07/04/2024 to cancel their transport for Residents #1 and #2 on 07/06/2024. She stated there was some misunderstanding and alternate dialysis transport arrangements were not made for Residents #1 and #2 for 07/06/2024. She stated the BOM was the Manager on Duty last weekend and discovered this mistake. She stated the BOM called the ED who directed her to transport Residents #1 and #2 with the facility van but the facility van driver had the keys with him at home. She said by the time the facility van driver brought the keys to the facility, Resident #1 and #2's scheduled dialysis appointments were past. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/12/2024 at 10:51 AM, the BOM stated she was the Manager on Duty on 07/06/2024. She said RN D informed her that Residents #1 and #2 did not have transportation to their dialysis appointments. She said the Receptionists made all the transport arrangements but there was no Receptionist at the facility on 07/06/2024. She said she called the contracted transport company who told her that they called Receptionist C on 07/04/2024 to inform her that they had to cancel transportation for Residents #1 and #2 on 07/06/2024 due to van maintenance issues. The BOM stated she called the ED who instructed her to transport Residents #1 and #2 with the facility van but the facility van driver had the keys at home with him. She stated by the time he brought the keys to the facility; the appointment time had passed, and dialysis had no other available appointments. She stated she did not call the MD to let them know of the missed dialysis appointments. She said she told the ED the appointments were missed, and the dialysis center would call back on 07/08/2024 to schedule follow up appointments for Residents #1 and #2. The BOM said she felt that there was a lack of communication, in that, Receptionist C did not follow up and reschedule transportation on 07/06/2024 for Residents #1 and #2 after the contractor cancelled the scheduled transport on 07/04/2024 for 07/06/2024. She stated the facility van keys should be at the facility and accessible to staff for backup transportation. She stated on 07/08/2024 the management team discussed both these issues in their stand-up meeting and the negative impacts missed dialysis appointments could have on resindets. She said residents who missed dialysis were at risk of fluid orverload and even death. In an interview on 07/12/2024 at 11:31 AM, the ADON stated he was informed of the missed dialysis appointments for Resident #1 and #2 on 07/08/2024 at the stand-up meeting. He stated the contract transport company called Receptionist C on 07/04/2024 to cancel their scheduled transport for 07/06/2024. He said Receptionist C did not inform anyone or make alternate arrangements for Resident #1 or #2's dialysis transport. The ADON said the facility failed to identify new transport for Residents #1 and #2 when regular transport was cancelled. The ADON said the facility's policy was to notify the MD for direction as a result of the missed dialysis treatment and document that direction. He stated residents were at [NAME] of fluid overload or even death if they missed dialysis appointments. In an interview on 07/12/2024 at 12:13 PM, CNA I stated he worked on 07/06/2024 and told RN D when he realized Resident #2's dialysis transport had not arrived. He stated he did not know what happened but Resident #2 did not get to her dialysis appointment during his shift. He said he had worked in the facility for seven years and did not recall any issues with dialysis transportation during that time. In a telephone interview on 07/12/2024 at 12:35 PM, the MD said neither he or his Physician Assistant were notified of Resident #1 and #2's missed dialysis treatments on 07/06/2024. He said he did expect to be notified because that was best practice, however both these residents were very stable, and he would not have done anything anyway. He stated if they had missed more than one dialysis treatment, he may have given direction for a change in treatment but not in this case. He said he reviewed the dialysis communication forms, for dialysis on 07/09/2024 and 07/11/2024, for both residents and had not concerns. He said there were no indications of any adverse effects to either resident as a result of the missed dialysis appointment on 07/06/2024. He said it was standard procedure to monitor the residents for signs and symptoms and report any changes to him at that point. He stated he never had any past concerns of the nursing staff not notifying him as needed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/12/2024 at 1:15 PM, Resident #2 said she did miss her scheduled dialysis treatment on 07/06/2024 because there was no transportation. She said she did not experience any medical issues as a result of missing dialysis on that day. She said she went to dialysis on 07/09/2024 and 07/11/2024 and the dialysis center did not raise any concerns. She said she had never had any transportation issues at the facility in the past. In an interview on 07/12/2024 at 1:27 PM, CNA J said he had worked at the facility for eight years. He said he worked on 07/06/2024 but was not aware of the transportation issues or missed dialysis appointments for Residents #1 and #2. He said the Receptionists arrange the transportation and he had never had an issue with transportation since he had worked in the facility. In an interview on 07/12/2024 at 1:41 PM, CNA K stated she worked on 07/06/2024 and was aware of the transportation issues. She said Resident #1 was ready to go to dialysis, but transport did not come. She said she informed RN D, who was working on getting the facility van keys to transport Resident #1 to her dialysis appointment. She stated this did not work and Resident #1 missed her appointment. In an interview on 07/12/2024 at 1:54 PM, Receptionist C stated the contracted transport company used by the facility on Saturdays, for Residents #1 and #2 dialysis appointments did call her on 07/04/2024 and cancel transport for 07/06/2024. She misunderstood them and did not think they were referring to the 6th. She said she received counseling from the ED because she had not informed anyone of the cancellation or made alternate arrangements. She said it was the Receptionist's duty to ensure transportation was secured for all resident's appointments. In an interview on 07/12/2024 at 2:03 PM, RN D said both Residents #1 and #2 missed their dialysis appointments on 07/06/2024. She said when she found out that the scheduled transporter had cancelled on 07/04/2024, she tried to reschedule the dialysis appointments for the center, but they did not have any alternate times available. She said the BOM did try to get the faculty van keys to make the transport herself but that did not happen timely as the van driver had taken the facility van keys home. She stated she had worked at the facility for a year and never had a problem with transport for residents in the past. RN D said the ED did direct her to make notification to the family and MD but she did not. She said she had an issue with another resident at the same time and overlooked making the notifications. She said both residents #1 and #2 were very stable and she did monitor for signs and symptoms related to the missed dialysis appointment, and none were noted. She said residents could be at risk of fluid overload if they missed dialysis appointments. In an interview 07/12/2024 at 2:30 PM, the ED stated the contacted transport company called Receptionist C on 07/04/2024 to cancel transport for Residents #1 and #2 on 07/06/2024. She said Receptionist C did not communicate that to anyone which resulted in no transportation on 07/06/2024. She stated the BOM called her, and she instructed her to make the transport for Residents #1 and #2 with the facility van. She said the van driver had the van keys at home with him and by the time he brought them to the facility, the appointment time had lapsed. She stated RN D tried to reschedule the dialysis appointments but there were no other times available. The ED said RN D did not notify the MD. She said RN D was counseled for this and Receptionist C was counseled for not arranging alternate transport when the company canceled. She said missed dialysis could result in fluid overload for the residents. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's, Manager on Duty Report, dated 07/06/24 at 1:30 PM, signed by the BOM, reflected, .Two dialysis pt missed, no transport made after [Contractor] called and cancelled, van broke down . Record review of the facility's Employee coaching and counseling record, dated 07/08/2024, and signed by the Executive Director, reflected Receptionist C received coaching, Employee failed to notify Admin staff after transportation company informed, they would not be available Sat [07/06/2024]. RN D received a coaching with the same date and reflected, [RN D] failed to notify and document missed dialysis appointments to family and physician. Record review of the facility's protocol titled, Following Dialysis Recommendations, dated August 2017, reflected, The Communities Director of Nursing Services and Regional Director of Dietary Services will establish and maintain communication with the dialysis centers to ensure continuity of care for all dialysis Residents. Record review of the facility's policy titled, Physician Notification, updated March 2019, reflected, .It is the responsibility of the nursing staff to observe the change, make an assessment, and notify the physician as indicated based on the assessment . The nurse will: Recognize the condition change, Monitor the Patient and continue to assess the condition and changes, Notify the physician, patient, and patient representative of any change in condition. Record review of the facility's undated policy titled, Transportation, reflected, .When doing Transportation, we first need to know is patient Riding with [Facility] or Transportation Company. Make sure if we have a driver available for the next following day always be in contact with the ED there might be a chance someone else is available especially if drivers are sick or when holiday come around. Always confirm with Nurse about dialysis appointments or appointments especially if you are not sure if patients are going or not sometimes, they refuse to go. Record review of the facility's policy titled, Transportation policy and procedure for facility-based vehicle, dated December 2019, reflected, In order for our Patients to maintain the highest practical physical, mental, and psychological well-being it is the policy of (nursing facility) to utilize the Facility vehicle for Patients who, because of medical or special needs, require transportation. Facility based vehicles are to be used solely to meet the needs of the Patients, including prearranged doctors' appointments and/or dialysis appointment, if Patients' responsible party is unable to meet transportation needs . Three sets of keys must be maintained for each Facility's vehicle. One set must remain in the possession of the authorized Facility driver, while on duty, one set must remain in the Executive Director's possession in a secure place and one set must be provided to the [Corporate] office. Violation of any part of this policy will result in disciplinary action up to termination.