

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  11/21/2024
NAME OF PROVIDER OR SUPPLIER  The Villa at Mountain View		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786</b></p> <p>Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 6 residents, (Resident #1) reviewed for care plans.</p> <p>The facility failed to ensure Resident #1's care plan reflected the resident's elopement risk and the use of a wanderguard.</p> <p>This failure could place the residents at risk of elopement and not receiving adequate care.</p> <p>Findings included:</p> <p>Record review of Resident #1's facesheet reflected a [AGE] year-old female, with an admitted [DATE]. Resident #1 had a diagnosis of alcohol dependence with withdrawal (sleep change, rapid changes in mood, and fatigue), Psychoactive Substance Abuse (the abuse of drugs that affect how the brain works and causes change in mood, awareness, thoughts, feelings, and behavior), Muscle Spasm (sudden, involuntary contraction of a muscle), Cognitive Communication Deficit (difficulty with communication that is caused by impaired cognitive processes), Generalized Anxiety Disorder (constantly worries about everyday things), Diabetes (high blood sugar), Depression (serious mental health condition that can affect a person's thoughts, feelings, behavior, and sense of well-being), and Essential Hypertension (high blood pressure).</p> <p>Record review of Resident #1's Quarterly MDS Assessment, dated 08/08/24, reflected Resident #1 had a BIMS score of 09, which indicated the resident had moderate cognitive impairment.</p> <p>Record review of Resident #1's Care Plan dated 11/19/24, did not address elopements or a Wanderguard.</p> <p>Resident #1's Elopement Risk assessment dated [DATE] reflected Resident #1 was not an elopement risk.</p> <p>Record review of Resident #1's Progress Notes dated 11/16/24, reflected the following:</p> <p>(continued on next page)</p>

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
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[Staff Member Name] came in making rounds to discover resident was not in room. [Staff Member Name] and manager searched each room on each hall in the building and outside parameter of facility and was unable locate resident. Code Pink was initiated. DON and Administrator made aware of situation, RP called, [City] PD called. Police showed up around 6:30 AM to begin searching in and around building following protocol for missing persons.</p> <p>In an interview on 11/21/24 at 2:15 PM, RN C stated the DON was responsible for ensuring the care plans were completed and updated. He stated some residents had elopements listed on their care plans, but he stated he was not sure if Resident #1 had it listed on her care plan. He stated he did know Resident #1 was an elopement risk, because any resident with a wanderguard was an elopement risk.</p> <p>In an interview on 11/21/24 at 2:34 PM, the DON stated she started working at the facility at the very beginning of April 2024 and did not think she was present when Resident #1 attempted to elope on 04/17/24. She stated she was probably still in training for her position. The DON stated a care plan probably should have been completed, but she could not say why it was not completed to address elopement or the wanderguard. She stated again, she was not the DON at the time of the incident or when Resident #1 started wearing a wanderguard. The DON stated she could not say if there was a risk of not adding to the care plan, due to her not being the DON at the time. She stated she did want to speak ill of the previous staff, but she stated she would have updated the care plan to address the attempted elopement and the wander guard usage. The DON stated the previous DON should have ensured the care plan was updated to address the risk of elopement.</p> <p>In an interview on 11/21/24 at 3:09 PM, the Administrator stated she could not speak on the care plan but felt the elopement risk and wander guard could have been addressed on the care plan. The Administrator stated the nursing team was responsible for care plans regarding elopements. She stated the care plan was not a big concern, but more so if Resident #1 was appropriately placed. The Administrator stated she did not feel the care plan did anything, because it was just a piece of paper. The Administrator stated the care plan would not have stopped Resident #1 from eloping.</p> <p>Record review of the facility's policy titled, Care Plans Comprehensive, dated 2001, with a revision date of 09/2010, reflected the following:</p> <p>Policy Statement</p> <p>An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs is developed for each resident.</p> <ol style="list-style-type: none"> <li>1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain.</li> <li>2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS:</li> <li>3. Each resident's comprehensive care plan is designed to:             <ol style="list-style-type: none"> <li>a. incorporate identified problem areas;</li> </ol> </li> </ol> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. incorporate risk factors associated with identified problems;</p> <p>9. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans:</p> <p>a. When there has been a significant change in the resident's condition;</p> <p>b. When the desired outcome is not met</p> <p>c. When the resident has been readmitted to the facility from a hospital stay; and</p> <p>d. At least quarterly.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786</b></p> <p>Based on record review and interview, the facility failed to ensure the resident environment remained free of accident hazards and that residents received adequate supervision to prevent incidents for two (Resident #1 and Resident #2) of two residents reviewed for elopement.</p> <ol style="list-style-type: none"> <li>1. The facility failed to provide Resident #1 and Resident #2 with adequate supervision to prevent each from leaving the building on 11/04/24 around 12:55 AM, when staff were not aware of the elopement until after 6:00 AM, at the start of the next shift.</li> <li>2. The facility failed to provide Resident #1 with adequate supervision to prevent Resident #1 from removing the Wanderguard and eloping the facility.</li> </ol> <p>The noncompliance was identified as past noncompliance. The Immediate Jeopardy was identified on 11/19/24 and was removed on 11/19/24. The facility corrected the noncompliance before the investigation began on 11/19/24. The Immediate Jeopardy occurred in the past and the facility had already corrected the non-compliance.</p> <p>These failures placed residents at risk for harm and serious injury.</p> <p>Findings Included:</p> <p>Record review of Resident #1's facesheet reflected a [AGE] year-old female, with an admitted [DATE]. Resident #1 had a diagnosis of alcohol dependence with withdrawal (sleep change, rapid changes in mood, and fatigue), Psychoactive Substance Abuse (the abuse of drugs that affect how the brain works and causes change in mood, awareness, thoughts, feelings, and behavior), Muscle Spasm (sudden, involuntary contraction of a muscle), Cognitive Communication Deficit (difficulty with communication that is caused by impaired cognitive processes), Generalized Anxiety Disorder (constantly worries about everyday things), Diabetes (high blood sugar), Depression (serious mental health condition that can affect a person's thoughts, feelings, behavior, and sense of well-being), and Essential Hypertension (high blood pressure).</p> <p>Record review of Resident #1's Quarterly MDS Assessment, dated 08/08/24, reflected Resident #1 had a BIMS score of 09, which indicated the resident had moderate cognitive impairment.</p> <p>Record review of Resident #1's Care Plan dated 11/19/24, did not address elopements or a Wanderguard.</p> <p>Resident #1's Elopement Risk assessment dated [DATE] reflected Resident #1 was not an elopement risk.</p> <p>Record review of Resident #1's Progress Notes dated 11/16/24, reflected the following:</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>[Staff Member Name] came in making rounds to discover resident was not in room. [Staff Member Name] and manager searched each room on each hall in the building and outside parameter of facility and was unable locate resident. Code Pink was initiated. DON and Administrator made aware of situation, RP called, [City] PD called. Police showed up around 6:30 AM to begin searching in and around building following protocol for missing persons.</p> <p>Record review of Resident #2's facesheet reflected a [AGE] year-old male, with an initial admitted [DATE], and a re-admitted [DATE]. Resident #1 had a diagnosis of Diabetes (high blood sugar), Sepsis ( life-threatening condition that occurs when the body's immune system has an extreme response to an infection or injury), Acute Kidney Failure ( sudden decline in kidney function), Hypertensive Chronic Kidney Disease ( severe high blood pressure caused kidney damage), Essential Hypertension (high blood pressure), Bipolar Disorder (serious mental illness that causes extreme mood swings, along with changes in energy, thinking, behavior, and sleep), Hemiplegia (partial or full paralysis on one side of the body), Accidental Poisoning by Opioids, and Shortness of Breath.</p> <p>Record review of Resident #2's Initial MDS Assessment, dated 08/23/24, reflected Resident #1 had a BIMS score of 15, which indicated the resident had intact cognition.</p> <p>Record review of Resident #2's Care Plan dated 11/19/24, did not address elopements.</p> <p>Record review of Resident #2's Progress Notes dated 11/01/24, reflected the following:</p> <p>patient unknowingly left the facility sometime in the early morning.</p> <p>In an interview with the Administrator and the DON, on 11/19/24 at 9:40 AM, the Administrator stated Resident #1 returned on 11/04/24, but could not tell them where Resident #2 was. The Administrator stated Resident #1 stated she and Resident #2 were hanging out in the hood, doing drugs, and she last saw Resident #2 in a shack. The Administrator stated Resident #1 and Resident #2 were in a relationship, and she felt Resident #2 was able to encourage Resident #1 to elope. She stated Resident #1's family member contacted the facility and told them Resident #1 went to visit a family member in another facility. Resident #1's family member brought Resident #1 back to the facility. She stated Resident #1 had no injuries. The Administrator stated Resident #1's BIMS score was 09, when she first admitted to the facility, but the facility reassessed her upon her return on 11/04/24 and her BIMS score was now a 15. The Administrator stated she assumed maybe since Resident #1 no longer had drugs in her system her BIMS score increased. The Administrator stated Resident #1 discharged to a group home a couple of days after she returned to the facility. The Administrator stated Resident #2 was never located, but she stated she received a tip that he might be at a local hospital. The Administrator stated she was able to confirm that Resident #2 was at a local hospital and provided the location and room number. The Administrator stated the hospital would not share any additional information on Resident #2 since he was no longer at the nursing facility. She stated she would see if she could confirm if he was admitted to the hospital. The Administrator stated Resident #1 and Resident #2 were not elopement risks prior to the elopement. The DON stated she started working at the facility after Resident #1 admitted , and she was not sure why she initially needed the Wanderguard. The DON stated the residents were usually checked on throughout the night, but like the Administrator stated some residents do not like to be checked on at night or were kind of independent. The DON stated Resident #1 and Resident #2 could do a lot on their own. The DON stated the two residents were often in the hallway together, so they had been seen by staff after 9:00 PM. The DON stated incoming staff from each shift were tasked with checking the Wanderguard residents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 11/19/24 at 10:46 AM, PD Detective stated the police station received the call about the elopement on 11/01/24 around 6:030 AM or 7:00 AM that morning. PD Detective stated she received a call from the nursing facility around 11/04/24 that Resident #1 had been located by her sister and returned to the facility. She stated Resident #2 was never located but stated the nursing facility only reported Resident #1 as missing and did not report Resident #2 as missing. The PD Detective stated she spoke with Resident #1, and she was currently living in a group home.</p> <p>In a telephone interview on 11/19/24 at 11:11 AM, Resident #2 stated he left the facility, because he hated the facility. He stated the food was always late and cold when he received it. Resident #2 stated he went back home, was safe, and did not have any injuries from eloping from the facility. He stated he felt safe at the facility, but it did not feel like home. He stated he was pretty much able to take care of himself. Resident #2 stated he did not plan on returning to the facility but would eventually go to a different rehabilitation facility. Resident #2 stated he had been in the hospital for about two weeks. He stated he went to the hospital to get his kidneys checked and to get a diagnostic of his kidney function.</p> <p>In a follow up interview on 11/19/24 at 2:44 PM, The Administrator stated Resident #1 had already admitted to the facility by the time she started working at the facility. She stated Resident #1 did have some issues with ambulating when she first admitted , but shortly afterward she began to ambulate. She stated she believed that was the reason she was given a Wanderguard. She stated the Wanderguard residents are checked at the beginning of every shift. She stated both Resident #1 and Resident #2 were both very independent and were able to do a lot of tasks on their own. The Administrator stated both residents would be seen around the facility together and were known to be in a relationship. She stated it was normal to see them around the facility together. She stated generally, residents were checked on every 2 hours, but Resident #2 was very independent and did not want to be checked on throughout the night. She stated staff got used to the residents and what they like or how each resident was.</p> <p>An Immediate Jeopardy for past non-compliance was identified on 11/19/24. The Administrator was notified of the Immediate Jeopardy for past non-compliance on 11/19/24 at 3:45 PM and were provided with the Immediate Jeopardy Template. The facility was not asked to provide a Plan of Removal, since the Immediate Jeopardy occurred in the past and the facility had already corrected the non-compliance.</p> <p>Record review of the following:</p> <p>Record review of the facility's Wanderguard Check Log reflected the staff checked Resident #1's Wanderguard at the beginning of every shift on 10/31/24 and the Wanderguard was intact.</p> <p>Record review of the Wanderguard Check Log reflected Wanderguards had been checked for all Wanderguard residents at the beginning of each shift since 11/01/24.</p> <p>Record review of Safe Surveys completed on all residents on 11/01/24. No residents had concerns related to the allegations.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of in-services completed on 11/01/24 that covered Timely Reporting/Recognizing Abuse, Neglect, and Misappropriation, Changes in Condition, Documentation, Physician Notification and Family, Clinical Rounds for assistance, Supervision/Needs, Call Lights, Rounding, and Customer Service for all staff from all shifts.</p> <p>Record review of the facility's Quality Assurance Meeting Minutes, dated 11/01/24, reflected the following:</p> <p>Discussion items</p> <p>Review of missing residents/elopement timeline</p> <p>Review of policies for sufficiency</p> <p>Residents elopement</p> <p>Record review of the facility's QAPI Plan dated 11/01/24, reflected the following:</p> <p>Immediate Actions Taken</p> <p>6:00 AM change of shift oncoming/outgoing nursing staff noted upon rounds that resident, [Resident #1 name] was not in her room. Code [NAME] (missing resident) was initiated with expansive room to room and facility search was immediately launched. With this search all other residents were accounted for except [Resident #1 name].</p> <p>6:30am-8:15am- all exit doors were validated to be functioning and working appropriately as well as the Wander Guard alarms. The Maintenance Director and Police reviewed the external camera tape, and it was noted that [Resident #1] exited the building walking alone (fully dressed in street clothes at 12:55 am); the review of the tape did not show [Resident #2] leaving out the facility front door but later discovery of the back gate camera noted he left with her at 12:55 am and walked across the street to [store name]. The last documented interaction with nurse for him was 2100 (9:00 PM).</p> <p>8am- The Maintenance Director, under the direction of the Administrator, changed the Wander Guard code for the doors.</p> <p>Systematic Approach:</p> <p>11/01/24- DON/Designees completed safe surveys on all interviewable residents to ensure that their needs are being met and that they felt safe- a pattern of concerns were noted with timeliness of call and staff knocking. Residents that were not interviewable were assessed by nursing for wellness and stability of their baseline. Education on rounding, answering call lights and knocking (customer service) was added to staff education.</p> <p>Nursing completed 100% of elopement assessments which revealed no new residents identified who are at risk for elopement. Wander Guard binder reviewed for accuracy.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Reviewed all 9 residents with Wander Guards to ensure/validate placement, functionality- 100% compliance; the Maintenance Director checked all exit doors and alarms to ensure proper functioning-no malfunction found.</p> <p>Education:</p> <p>Staff in-services initiated the following abuse prevention policy, resident rights, missing; elopement policy; Timely reporting/Recognizing abuse, neglect and misappropriation: Changes in Condition; Documentation; Physician Notification and Family clinical round for assistance, supervision and needs; Answer the Call-Inservice on answer call lights, rounding and customer service.</p> <ol style="list-style-type: none"> <li>Clinical staff will not be allowed to work their scheduled shift until they have completed all their education.</li> <li>Training for all newly hired staff will be completed prior to being assigned to the floor beginning on 11/01/24 with monitoring through 12/01/24. This will continue for all new hires.</li> <li>Training for all PRN staff who haven't worked since 10/31/24 will be completed prior working beginning 11/01/24 with monitoring through 12/01/24. This will continue ongoing for any staff not having been trained upon return to work.</li> <li>Training for all current direct care staff began on 11/01/24 and will continue until 100% completion of a test covering abuse prevention and elopement protocols.</li> <li>Elopement drills initiated on 11/01/24 will be completed on 3 shifts in the next 24 hours to be inclusive of a weekend shift on 11/02/24.</li> <li>Administrator and DON educated by the Regional Director of Clinical Services on abuse prevention policy, resident rights, missing/elopement policy; Timely Reporting/Recognizing abuse, neglect, and misappropriation: Changes in condition; documentation; physician notification and family and clinical rounds for assistance, supervision and needs.</li> </ol> <p>Monitoring:</p> <ol style="list-style-type: none"> <li>On-going education competency to ensure staff understanding of our abuse prevention policy, elopement policy and drill. This will be monitored by the DON and/or designees through observations and interviews and include: <ol style="list-style-type: none"> <li>Verbal questions/answers to ensure understanding</li> <li>The Nurse will report on residents with elopement/wandering behavior problems or care issues daily and prn during the morning IDT <ol style="list-style-type: none"> <li>Rounding to ensure prevention methods are in place has been completed daily beginning 11/01/24.</li> <li>DON or designee will conduct daily documentation review of all clinical notes to monitor any incidents that require supervision and intervention or additional training needs of facility staff.</li> </ol> </li> </ol> </li> </ol> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>3. DON will submit audit findings to the QA Committee for review, analysis and recommendations.</p> <p>4. Rounding completed by DON and/or designees to ensure identification of residents who at risk for elopement daily beginning 11/01/24 and will continue daily for 4 weeks, then weekly for 3 months, then monthly thereafter.</p> <p>5. DON or designee will conduct a weekly random audit for a period of 4 weeks ensuring nursing staff will continue to follow facility system for residents that at risk for elopement/wandering.</p> <p>6. DON or designee will conduct daily documentation review of all clinical note to monitor any incidents that require supervision and intervention or additional training needs of facility staff.</p> <p>7. DON will submit audit findings to QA Committee for review, analysis and recommendations.</p> <p>8. Maintenance Director-Elopement Drills initiated on 11/01/24 will be completed on three shifts in the next 24 hours to be inclusive of a weekend shift on 11/02/24, quarterly and PRN.</p> <p>9. Administrator Designees along with the local police will continue to search and investigate the whereabouts of the residents with all available means.</p> <p>In an interview at 11/20/24 at 2:01 PM, the ADON stated she was not present for the elopement, but immediately following the elopement, she and other staff were in-serviced on elopements, resident rights, customer service, rounding, call lights, abuse, neglect, and completed elopement drills. She stated no other residents had eloped since the incident with Resident #1 and Resident #2.</p> <p>In an interview on 11/21/24 at 12:57 PM, the Nutrition Aide stated she was trained on abuse and neglect, resident rights, customer service, and elopement. She stated the staff recently received in-services on resident rights, customer service, resident rights, and elopements. She stated she completed an elopement drill.</p> <p>In an interview on 11/21/24 at 1:25 PM, the CNA A stated she was not present during the elopement, but received in-services this month on abuse and neglect, resident rights, rounding and customer service, call light times, elopement, and participated in an elopement drill. She stated the norm was to check on all residents every two hours unless the resident needs something before the 2 hours. CNA A stated she usually checked on residents with Wanderguards more often.</p> <p>In an interview on 11/21/24 at 2:00 PM, LVN B stated she was not present during the elopement but was at work the morning afterward. She stated that same day, she received in-services on abuse and neglect, resident rights, customer service, call light times, rounding, and elopement. She stated she was present for an elopement drill. She stated all residents should be checked on every two hours or less, and Wanderguards were checked at the start of each shift.</p> <p>In an interview on 11/21/24 at 2:15 PM, RN C stated he was not at the facility during the elopement but worked the next day. He stated everyone in the facility was in-serviced on abuse and neglect, resident rights, rounding, customer services, elopement, and had an elopement drill. He stated all residents should be checked every two hours and Wanderguards are checked at the beginning of each shift. RN C stated he tried to check on his residents every hour on his hall. He stated he would sometimes sit in the hall closer to the residents.</p> <p>(continued on next page)</p>		

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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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In a follow-up interview on 11/21/24 at 2:34 PM, the DON stated she felt everything went smoothly with the elopement. She stated protocols were followed once the staff realized the residents were missing. The DON stated some residents were more independent, and Resident #1 and Resident #2 were in a relationship. She stated staff tried to give them space for their friendship, and she felt Resident #1, and Resident #2 would have gotten out of the facility no matter what. The DON stated after the elopement, all staff were in-serviced on elopement and completed elopement drills. She stated Wanderguards were checked at the beginning of every shift. The DON stated Resident #1 had become very independent over her stay at the facility. The DON stated she felt there was no risk of it taking the staff hours to notice Resident #1 and Resident #2 were missing. She stated she thought the staff realized sooner than 6:00 AM but would try to find documentation to support that. She stated the facility staff contacted her and the Administrator as soon as staff realized the residents were missing. She stated the physicians, family members, and police were notified at that time.</p> <p>In a follow-up interview on 11/21/24 at 3:09 PM, the Administrator stated staff did check on Resident #1 that night, but her bed was fixed with pillows that made it appear she was in the bed. She stated Resident #2 was very independent. She stated staff would not check on her as often, because she was independent, and she was out in the hallways often. The Administrator stated rounding was usually every two hours, including for Wanderguard residents. She stated the staff of the morning shift did exactly what they were supposed to do they noticed the residents were missing. She stated she felt there were no risks of staff not immediately noticing staff were missing during the night shift.</p> <p>Record review of the facility's policy titled, Elopements, dated 2001 with a revision date of 12/2007, reflected the following:</p> <p>Staff shall investigate and report all cases of missing residents.</p> <p>1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>44786</p> <p>Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen.</p> <ol style="list-style-type: none"> <li>The facility failed to ensure food stored in the refrigerator, freezer, and pantry were labeled, dated, and sealed.</li> <li>The facility failed to ensure a trash can in the food prep area had a lid.</li> <li>The facility failed to ensure lighter fluid was not stored in the dry food storage area.</li> </ol> <p>These failures could place residents at risk for food contamination and food-borne illness.</p> <p>Findings included:</p> <p>Observation on 11/21/24 beginning at 12:21 PM revealed the following items:</p> <p>Refrigerator:</p> <ol style="list-style-type: none"> <li>16 cups of various juices not labeled or dated</li> <li>one bowl of barbeque, shredded chicken, not labeled or dated</li> </ol> <p>Dry Storage Room:</p> <ol style="list-style-type: none"> <li>One bag of dry cereal in a plastic storage bag, not sealed</li> </ol> <p>Freezer:</p> <ol style="list-style-type: none"> <li>10 LBS box of breaded chicken breast, not sealed</li> <li>Box of breaded yellow squash, no sealed</li> <li>Freezer burned, slab of pork ribs in a plastic bag, no sealed, labeled or dated</li> </ol> <p>Food Preparation Area:</p> <ol style="list-style-type: none"> <li>One Trash can, full of trash, with no lid</li> </ol> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/21/24 at 12:57 PM, the Nutrition Aide stated she was trained on labeling, dating, and sealing food items. She stated all dietary staff were responsible for ensuring all items were labeled, dated, or sealed properly. The Dietary Aide said these tasks would occur throughout the shift. The Dietary Aide stated the risk of not labeling, dating, or sealing an item was food spoilage, sick residents, or termination of staff.</p> <p>In an interview on 11/21/24 at 1:09 PM, the Dietary Manager stated all dietary staff had been trained on labeling, dating, and sealing items. He stated he has had issues with his staff remembering to seal all food items. The Dietary Manager stated he would re-in-service his staff on labeling, dating, and sealing items. The Dietary Manager stated he usually left the trash can lids on the trans cans. He stated the risk of it all was cross contamination.</p> <p>In an interview on 11/21/24 at 3:09 PM, the Administrator stated the risk of not labeling, dating, storing food properly, and containing the trash was contamination.</p> <p>Record review of the facility's undated policy titled, Food Storage, reflected the following:</p> <p>POLICY:</p> <p>Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored, prepared, and transported at an appropriate temperature and by methods designed to prevent contamination.</p> <p>PROCEDURE:</p> <p>4. Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must legible and accurately labeled, including the date the package was opened.</p> <p>5. Chemicals must be clearly labeled, kept in original containers when possible, and kept in a locked area away from food.</p> <p>13. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 2-3 days or discarded.</p> <p>15. Refrigeration:</p> <p>e. All foods should be covered, labeled and dated.</p> <p>16. Frozen Foods:</p> <p>c. Foods should be covered, labeled and dated.</p> <p>Record review of the facility's policy, titled, Sanitization, dated, 2001, with a revision date of 10/2008, reflected the following:</p> <p>Policy Statement</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The food service area shall be maintained in a clean and sanitary manner.</p> <p>Policy Interpretation and Implementation</p> <p>1. All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects.</p> <p>13. Kitchen wastes that are not disposed of by mechanical means shall be kept in clean, leakproof, nonabsorbent, tightly closed containers and shall be disposed of daily.</p> <p>17. The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786</b></p> <p>Based on interviews and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were completed and accurately documented for 1 of 6 residents (Resident #1) observed for accuracy of medical records.</p> <p>The facility failed to complete an incident report when Resident #1 removed her Wanderguard and attempted to elope from the facility on 04/17/24.</p> <p>This deficient practice could place residents at risk for elopement and possible injury.</p> <p>The findings included:</p> <p>Record review of Resident #1's facesheet reflected a [AGE] year-old female, with an admitted [DATE]. Resident #1 had a diagnosis of alcohol dependence with withdrawal (sleep change, rapid changes in mood, and fatigue), Psychoactive Substance Abuse (the abuse of drugs that affect how the brain works and causes change in mood, awareness, thoughts, feelings, and behavior), Muscle Spasm (sudden, involuntary contraction of a muscle), Cognitive Communication Deficit (difficulty with communication that is caused by impaired cognitive processes), Generalized Anxiety Disorder (constantly worries about everyday things), Diabetes (high blood sugar), Depression (serious mental health condition that can affect a person's thoughts, feelings, behavior, and sense of well-being), and Essential Hypertension (high blood pressure).</p> <p>Record review of the progress notes, dated 04/17/24 on Resident #1's electronic record reflected the following:</p> <p>Resident removed wander guard and stated that she wants to go home and tried to exit on the front door. Resident up and down, continue going back and forth to the front door. [Staff Member name] manager notified. 1:1 assistance with resident initiated.</p> <p>Resident has new order for 1:1 monitoring due to elopement risk. Resident removed wander guard and threw it in the [trash] because she doesn't want anyone tracking her.</p> <p>Record review of the facility's incident report log, dated 11/20/24 did not reflect any incident report completed for the incident.</p> <p>In an interview on 11/21/24 at 2:34 PM, the DON stated she started working at the facility at the very beginning of April 2024 and did not think she was present when Resident #1 attempted to elope on 04/17/24. She stated she was probably still in training for her position. The DON stated she could not locate an incident report for the incident on 04/17/24. She stated she was not sure why an incident report was not completed. The DON stated the previous DON would have been responsible for ensuring an incident report was completed. The DON stated an incident report probably should have been completed. She stated the risk was the incident report could have noted her tendency to attempt to elope, possibly prevented an elopement, and there was no incident report documented.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 11/21/24 at 3:09 PM, the Administrator stated the DON at the time would have ensured all incident reports were completed. The Administrator stated there would not have been an incident report completed unless Resident #1 actually eloped. She stated there would not have been an incident report completed since she did not actually leave the premises during her elopement attempt in April. The Administrator stated she felt there was no risk of no incident report, because there was actually no major incident.</p> <p>Record review of the facility's policy titled, Accidents/Incidents, dated 07/2015, reflected the following:</p> <p>An Accident/Incident Report must be completed immediately upon Facility staff becoming aware of the occurrence of an accident/incident (to include medication errors) involving a Patient and, if necessary, the Patient's Care Plan must be updated.</p> <p>Record review of the facility's policy titled, Wandering Patients, dated 02/2020, reflected the following:</p> <p>WANDERING PATIENTS</p> <p>PURPOSE</p> <p>The purpose of this policy and procedure is to determine which Patients are considered wanderers and by what means the wandering Patients are accounted for.</p> <p>DEFINITION</p> <p>A Patient is considered to be a wanderer when he/she aimlessly and without purposeful intent walks or propels him/her self inside or outside the Patient. In addition, a Patient who places themselves at risk via wandering is the one who attempts to wander into unsupervised areas, has cognitive impairments that affect their ability for decision making with regard to appropriate dress and wandering safe areas OR the Patient has a physical impairment that impacts their ability to wander safely.</p>		