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	04/11/2025

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** 32581 Based on interviews and record reviews the facility failed to immediately inform his or her authority, the resident representative(s) when there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention and when a need to transfer or discharge the resident from the facility for 1 (Resident #1) of 6 residents reviewed for Change in condition. 1.LVN D failed to notify FM 1 after Resident #1 had an unwitnessed fall and complained of back pain on 04/06/25 at 2:50 am. 2.RN E failed to notify FM about Resident #1's transfer to the hospital after he fell with abnormal x-rays of his back on 04/06/25 around 3:26 pm. These failures could place residents with fall incidents or abnormal radiology reports at risk of a delay in prompt medical decisions, which could result in a decline in a resident's health and psycho-social well-being. Findings included: Record review of Resident #1's Admission MDS Assessment completed on 04/02/25, by MDS M revealed Resident #1 was an [AGE] year old male who admitted to [This Facility] on 03/25/25 with a BIMS score of 09 (Moderate Cognitive Impairment). He was dependent (2 person helpers did all assist) with toileting, showering/bathing, lower body dressing and putting on footwear. And partial to moderate assist with bed mobility and transfers. He was occasionally incontinent with bladder and always incontinent with bowel. His active diagnoses were medically complex conditions and he was diagnosed with atrial fibrillation, HTN, BPH, diabetes, hyperlipidemia, metabolic encephalopathy, acute pancreatis without infection, diverticulitis of small intestines without perforation or abscess. He had a history of falling within the past month. And based on Braden and clinical assessment he was at risk for pressure injuries and had 1 or more pressure injuries, Record review of Resident #1's Care Plan dated 04/08/25 for bladder incontinence related to confusion and impaired mobility, 03/31/25 Pressure Ulcer and enhanced barrier precautions implemented related to pressure ulcer. And 04/06/25 risk for falls. (continued on next page)

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
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Face Sheet dated 04/08/25 revealed only one FM listed [FM 1] as the Responsible party and Resident #1 was the alternate contact. (FM 2 was not listed). Record review of Resident #1's Nurse Progress notes by LVN D dated 04/06/25 at 2:37 am revealed, Resident was found on the floor in his room next to his bed while CNA was making rounds. resident is unable to verbalize what happened. We were able to put resident back into the bed, when asked if he had injured himself, he pointed to his low back. neuro-checks were initiated and within normal limits, vital signs Temp 97.9-Blood Pressure-146/80-Respirations 16-Saturations 97% Room Air. Call To MD/NP received new orders for X-ray for lumbar spine and bilateral Lower Extremity. Family, DON/ADON informed. will continue to monitor condition. Record review of Resident #1's Nurse Progress notes by LVN D dated 04/06/25 at 4:02 am revealed, XR (x-ray) requested for Lumbar Spine and Bilateral Hips. Record review of Resident #1's Nurse Progress note by RN K dated 04/06/25 at 11:13 am revealed, Resident continues neuro checks due to recent fall. No pain or discomfort noted. Patient resting in bed. respirations even and unlabored. Medications given per orders. Record review of Resident #1's Nurse Progress note by RN E dated 04/06/25 at 3:36 pm revealed, x-ray of spin and bilateral hip results received provider hotline called, reviewed results with NP H, order to send to ER for evaluation. Responsible party made aware. Record review of Resident #1's Nurse Progress note by RN E dated 04/06/25 at 6:52 pm revealed, FM 2 was in the facility on day shift, made aware of resident's fall and pending x-ray by day shift staff, FM 2 exited the facility, FM 2 called the facility multiple times, left note with the receptionist for charge nurse to call him back to follow up on Resident #1's pending x-rays, this charge nurse called FM 2 back and FM 2 stated I came to visit Resident #1 a few hours ago, I was informed that Resident #1 fell and there were pending x-rays, are the results available yet? this charge nurse stated the x-ray results had been received and the NP was made aware of the results and the NP wanted to send the resident out for further evaluation, FM 2 said ok, he will come in and pick up a few things for Resident #1 such as his wallet and a few other items Resident #1 may want, FM later came into facility, this charge nurse informed FM that resident was transported to hospital for further evaluation pending x-ray results. Record review of Resident #1's Nurse progress note by RN E dated 04/06/25 at 9:35 pm revealed, Resident returned from [The Hospital] with no new orders, np made aware FM made aware @ (at) phone # (number). Record review of Resident #1's Change of condition completed by unknown staff dated 04/06/25 at 6:55 pm revealed, this change started 04/06/25 this afternoon. Resident's vitals were taken that were normal and he had an abnormal spine x-ray. The Resident Representative Notification was blank and there was not a signature on who completed this form. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Radiology Report dated 04/06/25 revealed, PROCEDURE: SPINE 1V SPECIFY LEVEL Status: Final, Reason for Study: M54.50 LOW BACK PAIN, UNSPECIFIED, SPINE 1V SPECIFY LEVEL: FINDINGS: Moderate L1 and mild L2-L3 vertebral body compression demonstrated. The age of the compression is indeterminate. Vertebral bodies show degenerative osteophytic spurring and narrowing of disc spaces. The bones appear diffusely demineralized. L5-S1 anterior fusion hardware present. No comparison study is available. CONCLUSION: Abnormal spine. Consider more sensitive imaging evaluation with CT/MRI as clinically directed. Record review of Resident #1's Incident Report dated 04/06/25 at 2:15 am revealed, Resident was found on the floor next to his bed by CNA. No apparent injuries. Resident Unable to give Description, Vital signs taken, complete body assessment completed and neuro-checks initiated. MD/NP Called received order for XR ((X-rays) of bilateral lower extremities and lumbar spine. No injuries noted at the time of incident, bedridden, oriented to person, pain aid 4 (moaning/groaning, facial grimacing, distressed), confused, incontinent, gait imbalance, impaired memory. Responsible party, DON and DR/NP notified. Record review of Resident #1's Hospital Record dated 04/06/25 4:26 pm revealed, He admitted for abdominal pain and fall. At 4:43 PM Resident #1 is an [AGE] year-old male with a PMHx of HTN, a-fib, acute ischemic Left middle cerebral artery stroke, pancreatitis, and diabetes mellites who presents to the Emergency Department via Emergency Medical Service from a nursing home status post a fall yesterday evening. Per nurse relaying EMS, nursing home staff noticed the patient had an Altered Mental Status after falling out of bed yesterday evening. Per patient, he has bad back pain, left lower quadrant abdomen tenderness, and has vomited an unknown number of times recently. History of present illness and review of system limited secondary to chronic aphasia. CT scan of abdomen and pelvis with no abnormal findings. Radiology report from nursing home conducted at 1:00 pm today shows L1-L3 compression, unknown if acute or chronic. No acute changes on hips/pelvis x-ray. Pt (patient) has extensive cardiac history and history of stroke. The Lumbar findings were seen on prior imaging studies. Patient escorted from Emergency Department via stretcher accompanied by Ambulance service. Patient being taken back to the [The Facility]. Intravenous line removed by this RN. Discharge papers and face sheet given to transport team. No belongings left in room on pt departure. This RN attempted to call nursing home to let them know pt (patient) is coming back, no one responded. Interview on 04/09/25 at 1:48 pm, FM 1 stated he did not get a call about Resident #1 falling from the facility staff last Sunday 04/06/25. He stated FM 2 visited Resident #1 and was given the information about him falling and going to the hospital. He stated FM #2 called him around 4:30 pm telling him about Resident #1 falling and went to the hospital Sunday 04/06/25. He stated on 04/06/25 around 6:00 pm he went to the facility to get more information and they said they did not know where he was and finally the lady said Resident #1 was at the hospital. He stated they called him Sunday 04/06/25 at 10:30 pm saying Resident #1 had returned from the hospital and the nurse was not able to say what the hospital results were. He stated the nurse said he was okay and that it was abnormal but he was not sure what was abnormal. He stated he asked when did Resident #1 fall and was told by RN Weekend Supervisor F he fell last night. He stated some 15 1/2 hours later they told FM 2 not on the face sheet about his fall and hospital transfer. He stated RN Weekend Supervisor F said Resident #1's fall was reported to her and they needed to resolve his concern about not being notified of Resident #1's fall and hospital transfer. He stated the weekend supervisor said she would call the DON and Administrator about this issue. He stated to this day he's not been explained as to how his father fell and what was abnormal. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/09/25 at 3:58 pm, CNA G stated on 04/06/25, she overheard Resident #1 had a fall on a previous shift and then he went to the hospital. She stated FM 1 was at this facility wanting to know about the fall and said no one had contacted him from this facility that he had gone to the hospital. She stated Resident #1 returned around 9:00 pm on 04/06/25. Interview on 04/10/25 at 9:55 am, the DON stated on 04/06/25 this past weekend, She stated Resident #1 fell and x-rays showed he had a lumbar spine that looked abnormal. She stated he was sent to the hospital and returned from the hospital and they confirmed the lumbar spine was a preexisting diagnosis. She stated RN E reached out to FM 2 and not FM 1 who was the responsible party . She stated she was not sure how she got confused, because she should have called FM 1 on the face sheet. She stated FM 1 spoke to the weekend supervisor about the matter. She stated she had not spoken to the staff about ensuring they spoke to the right family member but planned to do. She stated they planned to talk to the staff this upcoming Friday about incident reporting, notifications, and call outs. She stated RN Weekend supervisor F talked to RN E to try to figure out why she did not do the communication correctly. She stated after reviewing with RN E the notification on face sheet, RN E said she thought she had the right person. She stated she had not had a chance to speak to RN E because the State Surveyor came to the facility. She stated she had been tied up and was not aware FM 1 had not been updated about Resident # 1's hospital visit. Interview on 04/10/25 at 10:41 am, the Administrator stated she thought FM 1 had a concern on the weekend of 04/06/25 about FM 2 being notified instead of him . She stated FM 2 visited Resident #1 and was told by the nurse he fell and was waiting for the x-ray results. She stated Resident #1 went to the hospital and had no complaints about why Resident #1 was sent to hospital and result afterwards. She stated on 04/06/25 at 2:37 am, Resident #1 was found on floor, in his room and the resident was unable to say what happened. She stated according to the nurses notes, the nurse called the Dr/NP and family. She stated she had no complaints from FM 1 about not being aware of Resident #1 falling, abnormal x-ray and transfer to the hospital. She stated he was sent back the same day 04/06/25 and the facility had no issues with FM 1 about the details of Resident #1's hospital visit and fall that she was aware of. Interview on 04/10/25 at 11:45 am, ADON A stated FM 1 said a few days ago Resident #1 went to the hospital and he was not informed. She stated FM 1 should have been informed because he was listed as the Responsible party. She stated she reviewed Resident #1's chart and FM 2 was not on it but FM 2 was in Resident #1's room visiting on 04/06/25. She stated she addressed this issue with RN E making sure they informed the right people on the face sheet because the RP needed to be notified for change of condition. She stated not being sure if FM 1 was notified of Resident #1 falling. She stated if the nurse called and left a message she should have called again then let upcoming nurse know to keep calling and go to next person on face sheet. She stated in Resident #1's case there was not a second contact person but RN E assumed FM 2 was the RP. She stated they planned to have a training with all staff to ensure no one was contacting the wrong person. She stated she was not aware of FM 1 complained about not being notified of the hospital visit findings. She stated the staff were supposed to call the RP to let them know the resident returned and outcome of hospital stay. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/11/25 at 10:59 am, Doctor J stated his NP H received the notice about Resident #1 fell and x-rays were ordered 04/06/25. She stated PA I was notified about the abnormal x-rays on 04/06/25 and sent the resident to the hospital. He stated Resident #1 fell out of bed and had bad back pain and had some vomiting. He stated he blood pressure and labs were fine and other vitals were fine and at the hospital he had a normal CT of his abdomen/pelvis. He stated Resident #1 had a diagnoses of diverticulitis and arthritis. He stated Resident #1's lumbar L1 and L2 were also negative and was sent back to this nursing facility the same day . Interview on 04/11/25 at 12:42 pm, LVN D stated she worked the 300 and 400 halls and on 04/06/25 around 1:30 or 2:30 am, Resident #1 fell . She stated the CNA told her he was on the floor and after he was assessed he was assisted back into his bed. She stated Resident #1 said he had pain and pointed to his lower back then she called NP H and she ordered x-rays for his lumbar and bilateral hips. She stated she called FM 1 but he did not answer and got a voice mail and she left a message to call [This Facility]. She stated FM 1 did not call back and she did not try to call FM 1 back, then she left at 6:15 am. She stated she documented he fell and she initiated neuro checks because he had an unwitnessed fall. She stated Resident #1 was on his back on the floor, between the 2 beds, he was lying flat on the floor with his knees up. She stated she found out later he was taken to the hospital for irregular x-rays. Interview on 04/11/24 at 1:24 pm, the Administrator stated they were trying to solve FM 1's complaints and they could not drop the ball again. She stated they had a meeting with FM 1 today 04/11/25 and FM 1 was giving them another opportunity to make things right for Resident #1. She stated not contacting the RP could potentially lead to the resident's needs not being met. She stated the DON was responsible for ensuring the change of condition process was done properly. She stated they were handling the issue with RN E and she was going to be written up and counseled, because she did not follow appropriate protocol. She stated FM 1 said when he came to the facility 04/06/25 to find out more information RN E was arguing with him that she had call him and he said no she did not call him. She stated RN E should have verified she spoke to the RP. She stated she was not aware LVN D did not call FM 1 after Resident #1 fell Interview on 04/11/25 at 10:09 am, RN E stated last Sunday 04/06/25 LVN K told her Resident #1 fell and neuro checks were needed. She stated FM 2 had visited earlier that day 04/06/25 and he found out about the fall and pending x-ray. She stated Resident #1 was in a little bit pain of pain of his lower back she told him he's going to the hospital for abnormal x-rays and he said okay. She stated she called NP H and got the order to send Resident #1 to the hospital for an evaluation. She stated Resident #1 was sent to the hospital around 3:00 pm or 4:00 pm because he had an abnormal lumbar x-ray. She stated FM 2 contacted her but she had not had the opportunity to call anyone yet, then she returned FM 2's call to follow-up with the x-ray result and told him what was going on and the resident was going to the hospital. She stated later that evening FM 1 said he was the RP and she responded she was unaware of that. She stated she normally looked at the face sheet to see who the RP was but did not in this case. She stated FM 1 wanted a follow-up on Resident #1's fall and x-ray results and she told him that she did not know the residents well on the 400 hall. She stated she was told FM 1 was the only RP Resident #1 had and to only contact him. She stated the DON told her to look at the resident's face sheets before talking to anyone about the residents. She stated the RP was upset and she apologized for not looking at the face sheet and not contacting him first. She stated around 10:00 pm Resident #1 returned back to the facility with no new orders. (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 Change in Condition policy undated revealed, CHANGE OF CONDITION Policy: To identify and evaluate a change in condition and notify the Physician and Responsible Party when indicated. A significant change in Resident's status is any sign or symptom that is Acute or sudden onset: - A marked change (i.e., more severe) in relation to usual signs and symptoms - New or worsening symptoms - Examples include but are not limited to the following: cardiovascular, respiratory, behavioral, fall with major injury, infection, dehydration, altered mental status, pressure injury and any other condition based on professional judgment. Procedure: When a change in condition occurs, the Licensed Nurse will: .3. Document date, time Physician, Responsible Party was notified of findings from the evaluation and any new orders obtained . 6. If the Physician chooses to send the Resident to the hospital for further evaluation and treatment, the charge nurse will initiate the transfer process. Evaluation findings will be documented on the communication tool used to transition the Resident to the next level of care.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on interviews and record reviews the facility failed to ensure the resident had the right to personal privacy and confidentiality of his or her personal and medical records for 1 (Resident #1) of 6 residents reviewed the Privacy of medical records. 1.LVN D failed to notify FM 1 after Resident #1 had an unwitnessed fall and complained of back pain on 04/06/25 at 2:50 am. The nurse notified FM 2 who was not on the face sheet. 2.RN E failed to notify FM about Resident #1's transfer to the hospital after he fell with abnormal x-rays of his back on 04/06/25 around 3:26 pm. The nurse notified FM 2 who was not on the face sheet. These failures could place residents with fall incidents or abnormal radiology reports at risk of a delay in prompt medical decisions, which could result in a decline in a resident's health and psycho-social well-being. Findings included: Record review of Resident #1's Admission MDS Assessment completed on 04/02/25, by MDS M revealed Resident #1 was an [AGE] year old male who admitted to [This Facility] on 03/25/25 with a BIMS score of 09 (Moderate Cognitive Impairment). He was dependent (2 person helpers did all assist) with toileting, showering/bathing, lower body dressing and putting on footwear. And partial to moderate assist with bed mobility and transfers. He was occasionally incontinent with bladder and always incontinent with bowel. His active diagnoses were medically complex conditions and he was diagnosed with atrial fibrillation, HTN, BPH, diabetes, hyperlipidemia, metabolic encephalopathy, acute pancreatis without infection, diverticulitis of small intestines without perforation or abscess. He had a history of falling within the past month. And based on Braden and clinical assessment he was at risk for pressure injuries and had 1 or more pressure injuries, Record review of Resident #1's Care Plan dated 04/08/25 for bladder incontinence related to confusion and impaired mobility, 03/31/25 Pressure Ulcer and enhanced barrier precautions implemented related to pressure ulcer. And 04/06/25 risk for falls. Record review of Resident #1's Face Sheet dated 04/08/25 revealed only one FM listed [FM 1] as the Responsible party and Resident #1 was the alternate contact. (FM 2 was not listed). Record review of Resident #1's Nurse Progress notes by LVN D dated 04/06/25 at 2:37 am revealed, Resident was found on the floor in his room next to his bed while CNA was making rounds. resident is unable to verbalize what happened. We were able to put resident back into the bed, when asked if he had injured himself, he pointed to his low back. neuro-checks were initiated and within normal limits, vital signs Temp 97.9-Blood Pressure-146/80-Respirations 16-Saturations 97% Room Air. Call To MD/NP received new orders for X-ray for lumbar spine and bilateral Lower Extremity. Family, DON/ADON informed. will continue to monitor condition. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Nurse Progress notes by LVN D dated 04/06/25 at 4:02 am revealed, XR (x-ray) requested for Lumbar Spine and Bilateral Hips. Record review of Resident #1's Nurse Progress note by RN K dated 04/06/25 at 11:13 am revealed, Resident continues neuro checks due to recent fall. No pain or discomfort noted. Patient resting in bed. respirations even and unlabored. Medications given per orders. Record review of Resident #1's Nurse Progress note by RN E dated 04/06/25 at 3:36 pm revealed, x-ray of spin and bilateral hip results received provider hotline called, reviewed results with NP H, order to send to ER for evaluation. Responsible party made aware. Record review of Resident #1's Nurse Progress note by RN E dated 04/06/25 at 6:52 pm revealed, FM 2 was in the facility on day shift, made aware of resident's fall and pending x-ray by day shift staff, FM 2 exited the facility, FM 2 called the facility multiple times, left note with the receptionist for charge nurse to call him back to follow up on Resident #1's pending x-rays, this charge nurse called FM 2 back and FM 2 stated I came to visit Resident #1 a few hours ago, I was informed that Resident #1 fell and there were pending x-rays, are the results available yet? this charge nurse stated the x-ray results had been received and the NP was made aware of the results and the NP wanted to send the resident out for further evaluation, FM 2 said ok, he will come in and pick up a few things for Resident #1 such as his wallet and a few other items Resident #1 may want, FM later came into facility, this charge nurse informed FM that resident was transported to hospital for further evaluation pending x-ray results. Record review of Resident #1's Nurse progress note by RN E dated 04/06/25 at 9:35 pm revealed, Resident returned from [The Hospital] with no new orders, np made aware FM made aware @ (at) phone # (number). Record review of Resident #1's Change of condition completed by unknown staff dated 04/06/25 at 6:55 pm revealed, this change started 04/06/25 this afternoon. Resident's vitals were taken that were normal and he had an abnormal spine x-ray. The Resident Representative Notification was blank and there was not a signature on who completed this form. Record review of Resident #1's Radiology Report dated 04/06/25 revealed, PROCEDURE: SPINE 1V SPECIFY LEVEL Status: Final, Reason for Study: M54.50 LOW BACK PAIN, UNSPECIFIED, SPINE 1V SPECIFY LEVEL: FINDINGS: Moderate L1 and mild L2-L3 vertebral body compression demonstrated. The age of the compression is indeterminate. Vertebral bodies show degenerative osteophytic spurring and narrowing of disc spaces. The bones appear diffusely demineralized. L5-S1 anterior fusion hardware present. No comparison study is available. CONCLUSION: Abnormal spine. Consider more sensitive imaging evaluation with CT/MRI as clinically directed. Record review of Resident #1's Incident Report dated 04/06/25 at 2:15 am revealed, Resident was found on the floor next to his bed by CNA. No apparent injuries. Resident Unable to give Description, Vital signs taken, complete body assessment completed and neuro-checks initiated. MD/NP Called received order for XR((X-rays) of bilateral lower extremities and lumbar spine. No injuries noted at the time of incident, bedridden, oriented to person, pain aid 4 (moaning/groaning, facial grimacing, distressed), confused, incontinent, gait imbalance, impaired memory. Responsible party, DON and DR/NP notified. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Hospital Record dated 04/06/25 4:26 pm revealed, He admitted for abdominal pain and fall. At 4:43 PM Resident #1 is an [AGE] year-old male with a PMHx of HTN, a-fib, acute ischemic Left middle cerebral artery stroke, pancreatitis, and diabetes mellites who presents to the Emergency Department via Emergency Medical Service from a nursing home status post a fall yesterday evening. Per nurse relaying EMS, nursing home staff noticed the patient had an Altered Mental Status after falling out of bed yesterday evening. Per patient, he has bad back pain, left lower quadrant abdomen tenderness, and has vomited an unknown number of times recently. History of present illness and review of system limited secondary to chronic aphasia. CT scan of abdomen and pelvis with no abnormal findings. Radiology report from nursing home conducted at 1:00 pm today shows L1-L3 compression, unknown if acute or chronic. No acute changes on hips/pelvis x-ray. Pt has extensive cardiac history and history of stroke. The Lumbar findings were seen on prior imaging studies. Patient escorted from Emergency Department via stretcher accompanied by Ambulance service. Patient being taken back to the [The Facility]. Intravenous line removed by this RN. Discharge papers and face sheet given to transport team. No belongings left in room on pt departure. This RN attempted to call nursing home to let them know pt (patient) is coming back, no one responded. Interview on 04/09/25 at 1:48 pm, FM 1 stated he did not get a call about Resident #1 falling from the facility staff last Sunday 04/06/25. He stated FM 2 visited Resident #1 and was given the information about him falling and going to the hospital. He stated FM #2 called him around 4:30 pm telling him about Resident #1 falling and went to the hospital Sunday 04/06/25. He stated on 04/06/25 around 6:00 pm he went to the facility to get more information and they said they did not know where he was and finally the lady said Resident #1 was at the hospital. He stated they called him Sunday 04/06/25 at 10:30 pm saying Resident #1 had returned from the hospital and the nurse was not able to say what the hospital results were. He stated the nurse said he was okay and that it was abnormal but he was not sure what was abnormal. He stated he asked when did Resident #1 fall and was told by RN Weekend Supervisor F he fell last night. He stated some 15 1/2 hours later they told FM 2 not on the face sheet about his fall and hospital transfer. He stated RN Weekend Supervisor F said Resident #1's fall was reported to her and they needed to resolve his concern about not being notified of Resident #1's fall and hospital transfer. He stated the weekend supervisor said she would call the DON and Administrator about this issue. He stated to this day he's not been explained as to how his father fell and what was abnormal. Interview on 04/09/25 at 3:58 pm, CNA G stated on 04/06/25, she overheard Resident #1 had a fall on a previous shift and then he went to the hospital. She stated FM 1 was at this facility wanting to know about the fall and said no one had contacted him from this facility that he had gone to the hospital. She stated Resident #1 returned around 9:00 pm on 04/06/25. (continued on next page)

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The Villa at Mountain View	2918 Duncanville Rd Dallas, TX 75211

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/10/25 at 9:55 am, the DON stated on 04/06/25 this past weekend, She stated Resident #1 fell and x-rays showed he had a lumbar spine that looked abnormal. She stated he was sent to the hospital and returned from the hospital and they confirmed the lumbar spine was a preexisting diagnosis. She stated RN E reached out to FM 2 and not FM 1 who was the responsible party. She stated she was not sure how she got confused, because she should have called FM 1 on the face sheet. She stated FM 1 spoke to the weekend supervisor about the matter. She stated she had not spoken to the staff about ensuring they spoke to the right family member but planned to do. She stated they planned to talk to the staff this upcoming Friday about incident reporting, notifications, and call outs. She stated RN Weekend supervisor F talked to RN E to try to figure out why she did not do the communication correctly. She stated after reviewing with RN E the notification on face sheet, RN E said she thought she had the right person. She stated she had not had a chance to speak to RN E because the State Surveyor came to the facility. She stated she had been tied up and was not aware FM 1 had not been updated about Resident # 1's hospital visit. Interview on 04/10/25 at 10:41 am, the Administrator stated she thought FM 1 had a concern on the weekend of 04/06/25 about FM 2 being notified instead of him. She stated FM 2 visited Resident #1 and was told by the nurse he fell and was waiting for the x-ray results. She stated Resident #1 went to the hospital and had no complaints about why Resident #1 was sent to hospital and result afterwards. She stated on 04/06/25 at 2:37 am, Resident #1 was found on floor, in his room and the resident was unable to say what happened. She stated according to the nurses notes, the nurse called the Dr/NP and family. She stated she had no complaints from FM 1 about not being aware of Resident #1 falling, abnormal x-ray and transfer to the hospital. She stated he was sent back the same day 04/06/25 and there were no issues with informing FM 1 about the details of his hospital visit and fall that she was aware of. Interview on 04/10/25 at 11:45 am, ADON A stated FM 1 said a few days ago Resident #1 went to the hospital and he was not informed. She stated FM 1 should have been informed because he was listed as the Responsible party. She stated she reviewed Resident #1's chart and FM 2 was not on it but FM 2 was in Resident #1's room visiting on 04/06/25. She stated she addressed this issue with RN E making sure they informed the right people on the face sheet because the RP needed to be notified for change of condition. She stated not being sure if FM 1 was notified of Resident #1 falling. She stated if the nurse called and left a message she should have called again then let upcoming nurse know to keep calling and go to next person on face sheet. She stated in Resident #1's case there was not a second contact person but RN E assumed FM 2 was the RP. She stated they planned to have a training with all staff to ensure no one was contacting the wrong person. She stated she was not aware of FM 1 complained about not being notified of the hospital visit findings. She stated the staff were supposed to call the RP to let them know the resident returned and outcome of hospital stay. Interview on 04/11/25 at 10:59 am, Doctor J stated his NP H received the notice about Resident #1 fell and x-rays were ordered 04/06/25. She stated PA I was notified about the abnormal x-rays on 04/06/25 and sent the resident to the hospital. He stated Resident #1 fell out of bed and had bad back pain and had some vomiting. He stated he blood pressure and labs were fine and other vitals were fine and at the hospital he had a normal CT of his abdomen/pelvis. He stated Resident #1 had a diagnoses of diverticulitis and arthritis. He stated Resident #1's lumbar L1 and L2 were also negative and was sent back to this nursing facility the same day. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/11/25 at 12:42 pm, LVN D stated she worked the 300 and 400 halls and on 04/06/25 around 1:30 or 2:30 am, Resident #1 fell . She stated the CNA told her he was on the floor and after he was assessed he was assisted back into his bed. She stated Resident #1 said he had pain and pointed to his lower back then she called NP H and she ordered x-rays for his lumbar and bilateral hips. She stated she called FM 1 but he did not answer and got a voice mail and she left a message to call [This Facility]. She stated FM 1 did not call back and she did not try to call FM 1 back, then she left at 6:15 am. She stated she documented he fell and she initiated neuro checks because he had an unwitnessed fall. She stated Resident #1 was on his back on the floor, between the 2 beds, he was lying flat on the floor with his knees up. She stated she found out later he was taken to the hospital for irregular x-rays. Interview on 04/11/24 at 1:24 pm, the Administrator stated they were trying to solve FM 1's complaints and they could not drop the ball again. She stated they had a meeting with FM 1 today 04/11/25 and FM 1 was giving them another opportunity to make things right for Resident #1. She stated not contacting the RP could potentially lead to the resident's needs not being met. She stated the DON was responsible for ensuring the change of condition process was done properly. She stated they were handling the issue with RN E and she was going to be written up and counseled, because she did not follow appropriate protocol. She stated FM 1 said when he came to the facility 04/06/25 to find out more information RN E was arguing with him that she had call him and he said no she did not call him. She stated RN E should have verified she spoke to the RP. She stated she was not aware LVN D did not call FM 1 after Resident #1 fell Interview on 04/11/25 at 10:09 am, RN E stated last Sunday 04/06/25 LVN K told her Resident #1 fell and neuro checks were needed. She stated FM 2 had visited earlier that day 04/06/25 and he found out about the fall and pending x-ray. She stated Resident #1 was in a little bit pain of pain of his lower back she told him he's going to the hospital for abnormal x-rays and he said okay. She stated she called NP H and got the order to send Resident #1 to the hospital for an evaluation. She stated Resident #1 was sent to the hospital around 3:00 pm or 4:00 pm because he had an abnormal lumbar x-ray. She stated FM 2 contacted her but she had not had the opportunity to call anyone yet, then she returned FM 2's call to follow-up with the x-ray result and told him what was going on and the resident was going to the hospital. She stated later that evening FM 1 said he was the RP and she responded she was unaware of that. She stated she normally looked at the face sheet to see who the RP was but did not in this case. She stated FM 1 wanted a follow-up on Resident #1's fall and x-ray results and she told him that she did not know the residents well on the 400 hall. She stated she was told FM 1 was the only RP Resident #1 had and to only contact him. She stated the DON told her to look at the resident's face sheets before talking to anyone about the residents. She stated the RP was upset and she apologized for not looking at the face sheet and not contacting him first. She stated around 10:00 pm Resident #1 returned back to the facility with no new orders.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on interviews and record reviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment. The comprehensive care plan must describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required for 1 (Resident #1) of 6 residents reviewed for care plans. The facility failed to ensure Resident #1's ADL care plan was completed to reveal what level a assistance he needed for dressing, toileting, bed mobility and transfers. This failure could place residents at risk of their needs not being met if staff did not know how to care for the residents properly, which could result in falls, pain, wounds and decreased psychosocial well-being and physical functioning. Findings included: Record review of Resident #1's Admission MDS Assessment completed on 04/02/25, by MDS M revealed Resident #1 was an [AGE] year old male who admitted to [This Facility] on 03/25/25 with a BIMS score of 09 (Moderate Cognitive Impairment). He was dependent (2 person helpers did all assist) with toileting, showering/bathing, lower body dressing and putting on footwear. And partial to moderate assist with bed mobility and transfers. He was occasionally incontinent with bladder and always incontinent with bowel. His active diagnoses were medically complex conditions and he was diagnosed with atrial fibrillation, HTN, BPH, diabetes, hyperlipidemia, metabolic encephalopathy, acute pancreatis without infection, diverticulitis of small intestines without perforation or abscess. He had a history of falling within the past month. And based on Braden and clinical assessment he was at risk for pressure injuries and had 1 or more pressure injuries, Record review of Resident #1's Comprehensive Care Plan dated 04/08/25 for bladder incontinence related to confusion and impaired mobility, 03/31/25 Pressure Ulcer and enhanced barrier precautions implemented related to pressure ulcer. And 04/06/25 risk for falls . Record review of Resident #1's Incident Report dated 04/06/25 at 2:15 am revealed, Resident was found on the floor next to his bed by CNA. No apparent injuries. Resident Unable to give Description, Vital signs taken, complete body assessment completed and neuro-checks initiated. MD/NP Called received order for XRs of bilateral lower extremities and lumbar spine. No injuries noted at the time of incident, bedridden, oriented to person, pain aid 4 (moaning/groaning, facial grimacing, distressed), confused, incontinent, gait imbalance, impaired memory. Responsible party, DON and DR/NP notified. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/11/25 at 12:14 pm, MDS L stated Resident #1 used to visit a resident here, now he was a resident. She stated Resident #1 was maybe a 1 person assist for transfers and 2 person assist for his other ADL's she believed. She stated she needed to get her computer. After she returned she stated Resident #1's Admission MDS Assessment showed he was substantial max assistance with ADL care and 1 to 2 staff with transfers. She stated Resident #1 should be care planned stated he was incontinent and not able to walk or weight bear. She stated Resident #1 had an ADL care plan and as she looked in the EMR she said she did not see one. She stated if Resident #1 required help he should have a care plan. She stated she was going to add the ADL care plan now and said it had not been added and she was not sure why. She stated multiple staff could add care plans and she captured the basic information and it was a team effort on doing the care plans. She stated she was ultimately responsible for ensuring the care plans were accurate and added the ADL Care plan (based on the MDS Assessment) and Plan of Care (based on the care plan the CNA's used) should have the same information. She stated the CNA's looked at the POC to know how to care for the residents. She stated they normally had two MDS Coordinators but not any longer. She stated it was just her now and there were a lot of residents she had to keep up with. She stated if the care plans were not accurate it could cause safety issues with the residents. She stated it would not allow them to care for the residents properly and to have interventions in place and proper care could be delayed. She stated she was off from work the other day and was not sure who filled in for her during that time. Interview on 04/11/25 at 1:24 pm, Administrator she stated she was not aware of any issues with Resident #1's ADL care plan being missing. She stated she planned to talk to the MDS Coordinator and nurse management because they should be working together to update the care plans. She stated the therapy department evaluated the residents to ensure they were all on the same page. She stated the IDT were supposed to create the acute care plans and the nurse managers were responsible for ensuring they were done . She stated the care plans should be the same as the MDS Assessments. She stated the care plan should tell the staff what the residents needs were. She stated if the ADL care plans were not accurate, the staff could potentially not meet the resident's needs. Interview on 04/11/25 at 2:39 pm, the DOR stated Resident #1 was getting skilled services for all three disciplines PT, OT, and ST since 03/26/25. She stated he was at baseline as far as his progress because he was not able to sustain his attention span. She stated they were working on his orientation today and time and motivating him to do therapy. She stated Resident #1's ADL was maximal assist for 2 person assist with toileting and bathing. She stated Resident #1 needed minimum assist for upper body dressing and moderate assist for lower body dressing and his mobility was inconsistent. She stated Resident #1 had good days and bad days with the same tasks depending on the level of his participation. She stated Resident #1 had a fall recently and was evaluated and to continue to educate fall risk on safety awareness. She stated there was no change with therapy level after he fell and was not able to weight bear or walk. She stated he was not able to toilet by himself due to his cognition and physical status. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Facility's Care Plan policy revised September 2010 revealed, Policy Statement: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy interpretation and implementation: 1. Our facility's Care Planning/Interdisciplinary team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. 3. Each resident's comprehensive care plan is designed to incorporate identified problem areas .assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. The Care planning/Interdisciplinary Team is responsible for review and updating of care plans: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 tc Based on interviews and record reviews the facility failed to ensure a resident received care, consistent with professional standards of practice, to prevent pressure ulcers and did not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable and once identified received services to promote wound healing for 1 (Resident #1) of 6 residents reviewed for Wound prevention. The facility failed to ensure Resident #1 did not develop a sacral wound after he admitted to this facility on 03/25/25; subsequently on 03/30/25, CNA C did not provide incontinent care to Resident #1 and the nurses or treatment nurses did not provided wound care to his sacral Deep Tissue Injury. And on 03/31/25 he developed an opened sacral wound. The facility failed to ensure Resident #1 did not develop a Left heel wound that was discovered on 04/09/25. These failures could place all residents at risk of acquiring wounds which could result in pain and infection and cause a decline in the resident's health and psycho-social well- being. Findings included: Record review of Resident #1's Admission MDS Assessment completed on 04/02/25, by MDS M revealed Resident #1 was an [AGE] year-old male who admitted to [This Facility] on 03/25/25 with a BIMS score of 09 (Moderate Cognitive Impairment). He was dependent (2 person helpers did all assist) with toileting, showering/bathing, lower body dressing and putting on footwear. And partial to moderate assist with bed mobility and transfers. He was occasionally incontinent with bladder and always incontinent with bowel. His active diagnoses were medically complex conditions and he was diagnosed with atrial fibrillation, HTN, BPH, diabetes, hyperlipidemia, metabolic encephalopathy, acute pancreatis without infection, diverticulitis of small intestines without perforation or abscess. He had a history of falling within the past month. And based on Braden and clinical assessment he was at risk for pressure injuries and had 1 or more pressure injuries. Record review of Resident #1's Care Plan dated 04/08/25 for bladder incontinence related to confusion and impaired mobility, 03/31/25 Pressure Ulcer and enhanced barrier precautions implemented related to pressure ulcer. And 04/06/25 risk for falls. (There was no care Plan for ADL Care). Record review of Resident #1's March 2025 MARS Skin Prep Wipes Miscellaneous (Ostomy Supplies) Apply to sacrum topically everyday shift for wound care Cleanse area with Normal Saline or Skin Cleanser. Pat Dry. Apply Skin Prep to affected area. Cover with Dry Dressing -Start Date- 03/27/2025 6:00 am Discontinued Date- 03/31/2025 2:15 pm. Eliquis Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for PREVENT CLOT-Start Date- 03/25/2025 at 7:00 pm. And on 03/30/25 there were no initials that his wound care treatment had been done. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's April 2025 MARS revealed, Wound Treatment - Hydrogel with silver everyday shift Cleanse wound to sacrum with Normal Saline or Skin Cleanser. Pat Dry. Apply Hydrogel to wound bed. Cover with Dry Dressing Start Date- 04/01/2025 at 6:00 am. Eliquis Oral Tablet 5 MG(Apixaban) Give 1 tablet by mouth two times a day for PREVENT CLOT -Start Date- 03/25/2025 7:00 pm. Record review of Resident #1's Nurse Progress Note dated 03/25/25 by RN N revealed, Skilled Note: Patient admitted to the facility under the skilled care of Doctor J with the DX (Diagnoses)) and HX (History)of Abdominal pain related to pancreatitis, Acute ischemic, Atrial fibrillation, Biventricular implantable cardioverter, Cardiomyopathy, CHF (Congestive Heart failure), Complete AV (Atrioventricular) block due to AV (Atrioventricular) [NAME] ablation, DM (diabetes Mellites) , and HTN. Patient is A/O (Alert/oriented) X 2, Spanish speaker with some understanding of English language. Incontinent of B/B (bowel/bladder), assist x 1 with Adl care. Patient continues on regular diet and regular liquid, skin is intact, no teeth no dentures. No s/s (signs/symptoms) of respiratory distress or pain noted or verbalized, skin warm and dry, bed lowered and call light within reach. Record review of Resident #1 Braden Scale for predicting pressure ulcer risk evaluation dated 03/25/2025 at 5:09 pm by RN N revealed, Sensory Perception: No impairment. Moisture: Occasionally moist. Activity: Chairfast. Resident is Slightly Limited: Makes frequent though slight changes in body or extremity position independently. Nutrition: Adequate. Friction and shear: Potential problem. BRADEN Score: 17.0 (at risk). Record review of Resident #1's Nurse Progress note dated 03/26/25 at 1:17 pm by RN S revealed, Skilled Note: Day 1/3 new admit. Resident is full code under skilled care of Dr J with the DX and HX of Abdominal pain related to pancreatitis, Acute ischemic, Atrial fibrillation, Biventricular implantable cardioverter, Cardiomyopathy, CHF, Complete AV block due to AV [NAME] ablation, DM, and HTN. Resident is primarily Spanish Speaking but understands some English. Writer introduced self as morning nurse. Full head to toe assessment shows no skin issues. Skin warm to touch dry and intact. Ear audible x2 with minimum wax build-up. Resident denies wearing hearing aids. Nares patent x2. Lips moist. Skin turgor good. No bleeding to gums noted. Teeth within reason. No thrush on tongue. Gag reflex present. Facial muscles present. No jvd (bulging jugular veins) noted. Able to MAEW (moves all extremities well). PT/ST/OT to eval. Denies pain at this time. Lungs CTA (CT angiogram of chest) A&P (anterior and posterior) bilaterally. breathing even and unlabored with no acute distress noted. No sob (Shortness of Breath) noted. No edema noted. PPP (pedal, pulses, palpable) present x4. BS (bowel sounds) present x4 quads. Resident is incontinent of B/B (bowel and bladder). Requires assist x 1 with Adl care such as grooming/transfers/bathing. Able to independently feed self with setup help only on NAS (no added salt) diet, Regular texture, Regular/Thin consistency. VS (vital signs) wnl (within normal limits). Resident orientated to call light/bedside remote. Repositioned for comfort. Care provided in timely manner. Call light within reach. Record review of Resident #1's Skin/Wound note dated 03/26/25 at 2:46 pm by Treatment Nurse B revealed, LATE ENTRY: Skin assessment completed. Dry skin to lower extremities and feet, moisturizer applied. Sacral area with purplish discoloration, Dr. notified, initiated wound consult, and wound care. Offloading with pillows, w/c cushion in place. No c/o pain voiced. Called FM 1, unable to leave message. Resident aware of treatment plan, no concerns voiced. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Baseline Care Plan dated 03/27/25 by RN S revealed, substantial/maximal assistance with sit to stand, chair/bed to chair transfer and toilet transfer, used a walker and wheelchair, always incontinent with bladder and bowel, used anticoagulants. 4. Skin risk was unchecked for current skin integrity and history of skin integrity issues. Record review of Resident #1 Skin/Wound note on 03/27/2025 at 9:42 am by Treatment Nurse B revealed, LATE ENTRY: Skin Issues: New skin Issue. Location: Sacrum. Issue type: Pressure ulcer / injury. Wound was present on admission. Signs and symptoms of infection: None. Painful: No. Staged by: In-house nursing. Length (cm): 6 Width (cm): 6 Depth (cm): 0 Undermining: No. Tunneling: No. Epithelial: 0%. Granulation: 0%. Slough: 0%. Eschar: 0%. Exudate amount: None. Exudate type: None. Odor after cleansing: None. Periwound: Attached. Surrounding tissue: Normal in color. Induration: None present. Edema: No swelling or edema. Periwound temperature: Normal. Dressing saturation: None 0%. Cleansing solution: Normal saline. Other primary dressing: SKIN PREP Secondary dressing: Dry. Modalities: None. Additional care: Mattress with pump. Additional care: Nutrition / dietary supplementation. Additional care: Mobility aid(s) provided. Additional care: Incontinence management. Additional care: Repositioning device(s). Skin issue education: Treatment of skin issue. Skin issue notification: Family. Skin issue notification: Provider. Skin issue notification: Wound nurse. Record review of Resident #1's Skin Issue progress note dated 03/31/2025 2:10 pm by Treatment Nurse B revealed Skin Issues : Skin Issue: #001: Skin issue has been evaluated. Location: Sacrum. Issue type: Pressure ulcer / injury. Progress: Stable: previously deteriorating wound characteristics plateaued. Pressure ulcer staging: Unstageable pressure ulcer / injury. Wound was present on admission. It is unknown how long the wound has been present. Signs and symptoms of infection: None. Painful: No. Staged by: Health care provider. Length (cm): 2.5 Width (cm): 6 Depth (cm): 0.2 Undermining: No. Tunneling: No. Epithelial:0%. Granulation: 80%. Slough: 0%. Eschar: 0%. Exudate amount: Light. Exudate type: Serous: clear watery fluid, which is separated from solid elements. Odor after cleansing: None. Other: not applicable. Other wound bed information: INTACT SKIN 20%Periwound: Attached. Surrounding tissue: Normal in color. Induration: None present. Edema: No swelling or edema. Periwound temperature: Normal. Dressing appearance: Intact. Dressing saturation: Minimal < 25%. Cleansing solution: Normal saline. Other primary dressing: hydrogel with silver Secondary dressing: Dry. Modalities: None. Additional care: Nutrition / dietary supplementation. Additional care: Repositioning device(s). Additional care: Mattress with pump. Additional care: Incontinence management. Additional care: Mobility aid(s) provided. Additional care: Pressure reducing device for chair. Skin issue education: Treatment of skin issue. Skin issue notification: Provider. Skin issue notification: Family. Record review of Resident #1's Skin/Wound note dated 03/31/2025 at 2:19 pm by Treatment Nurse B revealed, Seen by wound NP for wound consult in am. Unstageable DTI to sacrum with light serous drainage noted, 20% intact skin. No c/o pain voiced. Tx changed to Hydrogel with silver and dressing daily. R/p present and observed wound, aware of tx plan. Low bed position, call light in reach. (continued on next page)

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	675783	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Mountain View	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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Skin/Wound note dated on 04/02/2025 3:08 pm by Treatment Nurse B revealed, Skin issue has been evaluated. Location: Sacrum. Issue type: Pressure ulcer / injury. Progress: Improving: overall wound characteristics improved. Pressure ulcer staging: Unstageable pressure ulcer / injury. Unstageable ulcer due to slough and / or eschar. Wound was present on admission. It is unknown how long the wound has been present. Signs and symptoms of infection: None. Painful: No. Staged by: Health care provider. Length (cm): 2.5 Width (cm): 5.5 Depth (cm): 0.2 Undermining: No. Tunneling: No. Epithelial: 0%. Granulation: 40%. Slough: 40%. Eschar: 0%. Exudate amount: Light. Exudate type: Serous: clear watery fluid, which is separated from solid elements. Odor after cleansing: None. Other: not applicable. Other wound bed information: 20% skin Periwound: Attached. Surrounding tissue: Normal in color. Induration: None present. Edema: No swelling or edema. Periwound temperature: Normal. Dressing appearance: Intact. Dressing saturation: Minimal < 25%. Cleansing solution: Normal saline. Debridement: Sharp. Other primary dressing: hydrogel with silver Secondary dressing: Dry. Modalities: None. Additional care: Pressure reducing device for chair. Additional care: Mattress with pump. Additional care: Incontinence management. Additional care: Nutrition / dietary supplementation. Additional care: Repositioning device(s). Additional care: Mobility aid(s) provided. Skin issue education: Treatment of skin issue. Skin issue notification: Family. Skin issue notification: Provider. Record review of Resident #1's Skin/Wound note dated 04/09/2025 at 6:09 pm by Treatment Nurse B revealed, Has skin issue has been evaluated. Location: Sacrum. Issue type: Pressure ulcer / injury. Progress: Improving: overall wound characteristics improved. Pressure ulcer staging: Unstageable pressure ulcer / injury. Wound was present on admission. It is unknown how long the wound has been present. Signs and symptoms of infection: None. Painful: No. Staged by: Health care provider. Length (cm): 2 Width (cm): 4. 5 Depth (cm): 0.2 Undermining: No. Tunneling: No. Epithelial: 0%. Granulation: 40%. Slough: 40%. Eschar: 0%. Exudate amount: None. Exudate type: None. Odor after cleansing: None. Other: not applicable. Other wound bed information: 20% skin Periwound: Attached. Surrounding tissue: Normal in color. Induration: None present. Edema: No swelling or edema. Periwound temperature: Normal. Dressing appearance: Intact. Dressing saturation: None 0%. Cleansing solution: Normal saline. Debridement: Sharp. Other primary dressing: hydrogel with silver Secondary dressing: Dry. Modalities: None. Additional care: Incontinence management. Additional care: Repositioning device(s). Additional care: Mobility aid(s) provided. Additional care: Mattress with pump. New skin Issue. Location: Left heel. Issue type: Diabetic foot ulcer. Wound acquired in-house. Wound is new. Painful: No. Staged by: Health care provider. Length (cm): 0.8 Width (cm): 0.7 Depth (cm): 0 Undermining: No. Tunneling: No. Epithelial: 0%. Granulation: 0%. Slough: 0%. Eschar: 0%. Exudate amount: None. Exudate type: None. Odor after cleansing: None. Other: not applicable. Other wound bed information: INTACT SKIN WITH PURPLE/ MAROON DISCOLORATION Periwound: Attached. Surrounding tissue: Normal in color. Induration: None present. Edema: No swelling or edema. Periwound temperature: Normal. Dressing saturation: None 0%. Cleansing solution: Normal saline. Other primary dressing: SKIN PREP Secondary dressing: No secondary dressing applied. Modalities: None. Additional care: Mobility aid(s) provided. Additional care: Repositioning device(s). Additional care: Mattress with pump. Skin issue education: Treatment of skin issue. Skin issue notification: Provider. Skin issue notification: Family. Record review of Resident #1's Skin/Wound note dated 04/09/2025 at 6:02 pm by Treatment Nurse B revealed, Seen by Dr. [NAME] in am for wound consult. Sacral wound improved with increased granulation tissue. No sx of infection noted. New area to left heel; intact skin with purple /maroon discoloration noted. New order for skin prep daily. Offloading with pillows, LAL mattress, vitamin therapy continues. No c/o pain voiced. Called R/p FM 1, updated on status of wounds and new orders. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's four (4)skin assessments by Treatment Nurse B revealed on: 03/27/25 at 9:52 am Skin issues: New issue - sacrum pressure injury, present on admission, no drainage, Attached: Edge appears flush with wound bed or as a sloping edge. Incontinence management. Skin prep with dry dressing. (6 cm x 6 cm x 0 cm). 03/31/25 at 2:10 pm Skin issues: Evaluated - sacrum pressure injury, stable, unstageable pressure injury, present on admission, light clear drainage, 20 % skin intact. Incontinence management, Attached: Edge appears flush with wound bed or as a sloping edge. Hydrogel with silver dry dressing. (2.5 cm x 6 cm x .2 cm). 04/02/25 at 3:08 pm, Skin issues: Evaluated - sacrum pressure injury, improved, unstageable pressure injury, present on admission, light clear drainage, 20% skin intact, incontinence management, Attached: Edge appears flush with wound bed or as a sloping edge, Hydrogel with silver dry dressing. (2.3 cm x 5.5 cm x .2 cm). 04/09/25 at 6:09 pm, Skin issues:#1. Evaluated - sacrum pressure injury, improved, unstageable pressure injury, present on admission, no drainage 20% skin intact, Attached: Edge appears flush with wound bed or as a sloping edge, Hydrogel with silver dry dressing. 2 cm x 4.5 cm x .2 cm. #2. New issue: Left heel diabetic foot ulcer, in-house acquired, Skin intact with purple/maroon discoloration, Attached: Edge appears flush with wound bed or as a sloping edge. mattress with pump, reposition device. Skin prep. (.8 cm x .7 cm x 0 cm). Record review of Resident #1's Wound care Doctor Notes from 03/31/25 to 04/09/25 revealed: 03/31/25 - Unstageable DTI sacrum undetermined thickness wound size (L x W x D) 2.5 x 6 x 0.2 cm. 04/02/25 - Unstageable due to necrosis sacrum full thickness wound size (L x W x D) 2.5 x 5.5 x 0.2 cm. 04/09/25 - (Site 1)Unstageable due to necrosis sacrum full thickness wound size (L x W x D) 2.0 x 4.5 x 0.2 cm. Focus wound exam (Site 2) Diabetic wound of left heel (L x W x D) .08 x o.7 x not measurable cm. Record review of Resident #1's Hospital Discharge Record dated 03/25/25 revealed, Hospital Discharge Summary dated 03/25/25 revealed, Primary Discharge Diagnosis: Acute pancreatitis (pancreas inflammation), resolved. Secondary discharge diagnosis: Acute metabolic encephalopathy (Brain Dysfunction), small bowel obstruction (blockage in intestines), diarrhea (loose watery stools), Diverticulitis of descending colon (inflamed or infected colon), Type 2 diabetes (high blood sugar), Essential hypertension (high blood pressure), paroxysmal A-fib (recurrent irregular heartbeat), CVA (Stroke), dilated cardiomyopathy (heart muscle disease), Discharge Disposition: Skilled Nursing Facility. Extremities: normal, atraumatic, no cyanosis or edema, Skin: Skin color, texture, turgor normal, no rashes or lesions. Hospital Problem list: Essential hypertension, benign prostate hyperplasia, paroxysmal atrial fibrillation, chronic anticoagulation, cognitive impairment, cerebrovascular accident, dilated cardiomyopathy, Principal: acute pancreatitis, small bowel obstruction, diverticulitis of descending colon. (There were not any Skin issues, rashes, DTI, or wounds listed). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/09/25 at 1:28 pm, FM 1 stated there was no report of Resident #1 having any skin issues at the hospital or when he first admitted to [This Facility] 03/25/25, then on 03/29/25 Treatment Nurse B said she discovered Resident #1 had a sacral wound. FM 1 stated when visiting Resident #1 on 03/30/25, Resident #1's clothes and bed was saturated with feces and urine that appeared reddish underneath Resident #1. FM stated he had to get staff to come in to change him and the CNA was not on the hall and they found her working another hall. FM 1 stated on 03/31/25 there was several people in the meeting as a new admission meet and greet and he brought up the sacral wound concern and why was he not notified of Resident #1's wound until 03/29/25. FM 1 said the Administrator tried to say Resident #1 checked in with that wound but FM 1 did not think that was true. FM 1 stated Treatment Nurse B said Resident #1 did not have a sacral wound when he first admitted . FM 1 stated on 03/31/25 he was able to see Resident #1's wound with the wound care NP and Treatment Nurse B in the room. FM 1 stated Treatment Nurse B admitted to him, Resident #1 was not changed the day before on 03/30/25 by CNA C. Interview on 04/09/25 at 10:52 am, the Treatment Nurse B stated Resident #1 had a pressure wound. She stated he admitted with a sacral pressure sore that had actually improved. She stated she assessed him the following day after he admitted on [DATE] and he had some purplish discoloration. She stated skin prep was ordered for skin protection. She stated she did skin assessments but his skin was not open until the wound care NP saw him 03/31/25. She stated Resident #1's treatment was changed to hydrogel with silver and dry dressing on 03/31/25. She stated that tended to happen with DTI they were superficial and will open up. She stated the nurse managers had daily standup meetings to discuss who had wounds, the statuses, and interventions to ensure they were on the same page. She stated they met to see if they needed to do something different. She stated Resident #1 initially had a purplish color on his sacral that was fading and granulating with minimum drainage. She stated Resident #1's sacral wound had no odors in the healing phase and he had no pain. She spoke to FM 1 about the wound and he came up to the facility to see the wound and he had concerns about Resident #1 being incontinent and being left wet. Interview on 04/09/25 at 3:35 pm, RN N stated he remembered assessing Resident #1 when he first admitted during the evening shift on 03/25/25. He stated he did a head-to-toe assessment of Resident #1 and he did not have any wounds or discolorations anywhere. He stated Resident #1 did not have a sacral wound and he stood on his word. He stated the next day the Treatment Nurse B did the skin assessments for all new admit residents. He stated if the residents skin was not checked regularly they might miss something and the resident's skin might turn to something like a wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/09/25 at 4:15 pm, LVN O stated she worked another hall two weekends ago on Sunday 03/30/25 and FM 1 said for three days he did not feel the staff were checking and changing Resident #1 that often. She stated FM 1 said he noticed the issue of Resident #1 not getting changed on the weekends and weekdays. She stated she had to talk to CNA C that day 03/30/25 who worked a split hall and had a few rooms on the 400 hall. She stated she asked CNA C why was Resident #1 soaking wet. C said she was not sure of Resident #1's care level. She stated she made sure Resident #1 was provided incontinent care, just before the CNA's shift was over. She stated Resident #1 was very soiled with brownish stains underneath him and stated she wrote a note and put it under the DON's door. She stated the note she left was about Resident #1 not being turned and changed and had to send CNA C into the room to do incontinent care on him. She stated she assumed the DON addressed it and did not call the DON about this matter the same day or next day She stated she had not worked at this facility since then and felt she took care of the issue with Resident #1 with getting him changed. She stated FM 1 said thanks so much and he said he was going to mention this issue in the meeting already scheduled for that Monday 03/31/25, with the DON and Administrator. She stated she was not his nurse that day it was LVN T and she was just passing by Resident #1's room and FM 1 stopped her around 1:00 pm. She stated FM 1 wanted Resident #1 changed because he was wet and after seeing the condition of the resident she went to the nursing station where LVN T was charting. She stated she had LVN T go into the room to see the condition of Resident #1 and then he was changed. She stated she did not think Resident #1 not being changed was neglect but it was miscommunication on what the CNA was supposed to do. She stated she told CNA C she still was supposed to check and provide care to Resident #1. Interview on 04/09/25 at 4:40 pm, CNA C stated she worked a double shift on 03/30/25 and onetime she worked a split on the 300 and 400 halls on 03/30/25 from 6:00 am to 2:00 pm. She stated she also worked the 500 hall on 03/30/25 from 2:00 pm to 10:00 pm . She stated she never worked the 400 hall and CNA P who normally worked that hall said Resident #1 was continent but he really was not. She stated it was a hard lesson for her to learn and said she checked Resident #1 once before breakfast and lunch and his sheets was not messed up. She stated FM 1 came around 3:00 pm and Resident #1's bed sheets were soaked and a mess they had orange colored urine and bowel movement in his brief. She stated she immediately changed him and she did not see any wounds on him anywhere. She stated she did not look at Resident #1's Plan of Care because she took the word of CNA P telling her he could walk and put his light on when he needed something. She stated she was a new CNA (just certified as a nurse aide) and went by the CNA's word and did not check to see that Resident #1 was incontinent. She stated she had access to the residents records and for now she would make sure she checked everybody to see if they needed incontinent care and toileting. She stated she did not want to base care on what she heard from CNA's and what happened to Resident #1 was a hard lesson to learn. She stated no one talked to her about ways to not ever do that again. She stated she was emotional and apologized about what happened to Resident #1 and FM 1 and they just looked at her and said thank you. She stated she was assigned 14 residents and CNA P worked the other side of hall 400. She stated LVN T was the nurse who worked the 400 hall and she was made aware of the situation. She stated the DON nor Administrator had not spoken to her about this and asked was she in trouble about this. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/10/25 at 9:55 am, the DON stated the wound care NP visited the residents every Mondays and the wound care Doctor visited the residents every Wednesday. She stated ADON A said Resident #1's son had some concerns about the timeliness of Resident #1's care, about how often he was being changed. She stated FM 1 was explained on the call light process, which was understandable with Resident #1 being new to their facility. She stated she explained to FM 1 how the staffing ratio was different from the hospital. She stated she was not aware Resident #1 was not changed for a long period of time on 03/30/25. She stated ADON A told her FM 1 said Resident #1 was wet, not soaking wet and she stated she did not call FM 1 about his complaint because ADON A said she handled it. She stated what they needed to do moving forward was to check more often on the residents and family about any concerns. She stated they were constantly training the staff on call light response and making sure they followed through on what they needed to do for the residents. She stated she never heard anything about Resident #1 not getting care on 03/30/25. She stated the splitting of halls fluctuated with the census. She stated they planned to have a meeting with FM 1 about his expectations. She stated there were no complaints from anyone about the care CNA C provided the residents. She stated CNA C usually worked the 500 hall and did a really really good job and added she was not sure if she had ever worked the split 400 hall, but she may have. She stated she had no complaints or issues with how LVN T provided care to the residents. She stated LVN T had not reported any issues with Resident #1 on 03/30/25. She stated Resident #1 admitted with a sacral wound and they did not take pictures of the wound when he admitted because the Treatment nurse assessed the residents once they admitted . She stated she was not sure when the Treatment Nurse B assessed Resident #1. She stated Resident #1 admitted with a sacral Deep Tissues Injury but his wound was intact. She stated she was not sure why Resident #1 was not diagnosed with a DTI when he admitted , she would have to ask the Treatment Nurse B . She stated she was not sure when Resident #1 got the sacral wound. She stated his sacral wound started out as a DTI and changed to a pressure wound or that area. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/09/25 at 10:41 am, the Administrator stated they had a new admission meeting with FM 1 on 04/02/25 about Resident #1's discharge planning. She stated FM 1 brought up an ADL grievance about Resident #1 being wet but not soaking wet. She stated FM 1 said Resident #1 was incontinent and there was delays in his care. She stated they told FM 1 Resident #1 admitted with a darkened area. She stated they told FM 1 the sacral discoloration was under his skin and it was not an open area. She stated after Resident #1 admitted the DTI opened up to a pressure wound. She stated she was not sure why RN N said Resident #1 skin was intact and had no discoloration when he admitted . She stated RN N was not trained in wound care like Treatment Nurse B. She stated she was not sure when the Treatment Nurse B first assessed Resident #1 maybe 03/26/25. She stated as of yesterday 04/09/25 Resident #1's sacral area was an unstageable pressure wound and he had a new diabetic non- pressure heel wound. She stated Resident #1 has had four wound care assessments on 03/27/25, 03/31/25, 04/02/25 and 04/09/25. She stated there were no issues with how often Resident #1 was changed with the exception of 03/30/25. She stated telling FM 1 the staff would be doing frequent rounds from shift to shift and communicate better between the nurses and CNA's. She stated telling FM 1 she had an open-door policy to her about any concerns. She stated no facility was perfect and FM 1 knew he could talk to them about any concerns. She stated she spoke to ADON A and she said she resolved FM 1's concern and all the aides working 03/30/25 were counseled because there was an issue with the assignments that day who worked the 400 hall. She stated now those staff received clarification on what residents they were assigned to care for. She stated the nurses needed to check behind the CNA's to ensure the care was being provided during their shifts. She stated she was not sure of the specifics of FM 1 complaint because ADON B handled it and she stated she was not sure if the nurses had been spoken to about the 03/30/25 incident with Resident #1. She stated there were no complaints with how CNA C and LVN T cared for the residents. She stated CNA C was disciplined about the confusion of her assignment in not providing care to Resident #1 on 03/30/25. She stated she did not talk to CNA C directly because she gave the directive for it to be handled by the ADON A. She stated all the staff knew their expectations and if Resident #1 not getting changed was a mistake or accident did not negate what happened. She stated they were all monitoring CNA C to ensure she was providing proper care to the residents. She stated no one brought to her attention the condition of Resident #1's bed being heavily soaked with bowel and urine because CNA C thought Resident #1 was continent but that was not an excuse she should have checked on him periodically and changed him. She stated Resident #1 was in a facility to get care. She stated they trained the staff about ADL care last Monday 04/07/25. She stated if a resident were left soiled for a long period of time they could have a negative outcome, anything could happened. She stated Resident #1 had care plans for sacral wound, bladder incontinence on 03/26/25, enhanced barrier precaution related to pressure ulcer on 03/31/25, bladder incontinence on 04/08/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/10/25 at 11:45 am, ADON A stated they had an Admission meeting earlier this month where all the staff introduced themselves to the new residents and family. She stated FM 1 had concerns about ensuring Resident #1 received appropriate care and they told FM 1 to come to her (ADON A) or other ADON U for his concerns. She stated two days ago FM 1 called her about the timing issue of Resident #1's incontinent care and she told him moving forward she would go out to check and see that Resident #1 was getting care every two hours. She stated she worked some weekends and some nights but not all the time but the charge nurses was also ensuring Resident #1 was being changed timely. She stated FM 1 said he came to visit and Resident #1 was soiled and was concerned with how long it was taking for the CNA's to change him. She stated she reviewed the schedule for 03/30/25 and there was a mix-up of the schedule. She stated CNA G worked the other end of the 400 hall during the 2:00 pm -10:00 shift on 03/30/25. She stated none of the staff reported Resident #1 was soaking wet with bowel and urine and not changed for a long period of time. She stated she was not sure who LVN O was. She stated the staff should have reported if a resident was heavily soaking wet with bowels and urine because of not being changed for a long period of time. She stated Resident #1 should not have been left that long without being changed, LVN T was his nurse 03/30/25 and she did not say anything about this incident either. She stated she spoke to CNA C about what happened and she said the thought Resident #1 was continent and did not provide any incontinent care to him on 03/30/25. She stated she did counseling with CNA C and told her moving forward she needed to make sure everyone was on the same page and knew the right assignment by looking at the schedule sheet. She stated she spoke to CNA C that she needed to speak to [TRUNCATED]

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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** 32581 Based on interviews and record reviews the facility failed to maintain medical records on each resident that were complete for 1 (Resident #1) of 6 residents reviewed for Medical records. MDS L or MDS M failed to add to Resident #1's EMR profile, of him having a sacral pressure ulcer he was diagnosed with on 03/31/25. These failures could place residents at risk of not getting appropriate care if the resident's documentation were missing from their medical profile which could cause missed care and treatment resulting in a decline in health and psycho-social well-being. Findings included: Record review of Resident #1's Admission MDS Assessment completed on 04/02/25, by MDS M revealed Resident #1 was an [AGE] year old male who admitted to [This Facility] on 03/25/25 with a BIMS score of 09 (Moderate Cognitive Impairment). He was dependent (2 person helpers did all assist) with toileting, showering/bathing, lower body dressing and putting on footwear. And partial to moderate assist with bed mobility and transfers. He was occasionally incontinent with bladder and always incontinent with bowel. His active diagnoses were medically complex conditions and he was diagnosed with atrial fibrillation, HTN, BPH, diabetes, hyperlipidemia, metabolic encephalopathy, acute pancreatis without infection, diverticulitis of small intestines without perforation or abscess. He had a history of falling within the past month. And based on Braden and clinical assessment he was at risk for pressure injuries and had 1 or more pressure injuries, Record review of Resident #1's Care Plan dated 04/08/25 for bladder incontinence related to confusion and impaired mobility, 03/31/25 Pressure Ulcer and enhanced barrier precautions implemented related to pressure ulcer. And 04/06/25 risk for falls. Interview on 04/11/25 at 12:14 pm, MDS L stated for the residents new diagnoses she was responsible for ensuring they were added to the residents EMR profile. She stated both ADON's and the DON could also add new diagnoses. She stated she was aware Resident #1 had a sacral wound and just found out while looking at his record he had a new left heel wound . She stated she would add his Sacral wound diagnoses to his EMR profile. She stated when resident's diagnoses were missing from their EMR profile it could cause safety issues and not allow them to care for them properly. She stated it could cause them to not have interventions in place and proper care could be delayed. Interview on 04/11/25 at 1:24 pm, the Administrator stated she was not aware of any issues with adding the residents diagnoses to their medical records. She stated the MDS L was not at work last Friday and called out and added they did not have another person designated for adding diagnoses. She stated the resident's diagnoses were needed in the EMR profile to adequately reflect the residents condition. She stated the MDS Coordinator was responsible for adding any new diagnoses to the resident's file. She stated Resident#1 has had the sacral wound for a couple of weeks. (continued on next page)

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	04/11/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Medical records policy was requested and on 04/11/25 at 3:30 pm, the Regional Nurse Consultant said they did not have one.