

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675811	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/22/2024
NAME OF PROVIDER OR SUPPLIER  Victoria Gardens of Frisco		STREET ADDRESS, CITY, STATE, ZIP CODE  10700 Rolater Dr Frisco, TX 75035	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45507</p> <p>Based on observation, interview and record review, the facility failed to ensure the residents received services in the facility with reasonable accommodation of each resident's needs for 3 of 9 residents (Resident #1, #20 and #21) reviewed for accommodation of needs in that:</p> <p>The facility failed to ensure that Resident #1, #20 and #21's call lights were in reach.</p> <p>This failure could affect all residents who needed assistance and could result in needs not being met.</p> <p>Findings included:</p> <p>Record review of Resident #1's Face Sheet, dated 3-21-2024, indicated a [AGE] year-old-female admitted to the facility on [DATE]. Resident #1 had a primary diagnosis of osteomyelitis (inflammation of bone or bone marrow, usually due to infection), multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), sepsis (a life-threatening complication of an infection), and glaucoma (a group of eye conditions that can cause blindness).</p> <p>Record review of Resident #1's MDS, dated [DATE], revealed a BIMS score of 3 indicating severe cognitive impairment and visual impairment. Resident #1's MDS further revealed Resident #1 rated a score of 1 for functional abilities indicating Resident #1 was dependent (Helper does all the effort. Resident does none of the effort to complete the activity and/or, the assistance of 2 or more helpers is required for the resident to complete the activity) for eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene.</p> <p>In an observation/interview, on 3-20-2024 at 11:10 AM, revealed Resident #1 was observed lying in bed and awake. Resident #1 was observed to not have her call light within reach. Resident #1's call light was observed to be 3 to 4 feet away from the bed on top of a refrigerator. Observation of the call light revealed it was a pressure call light, with a wide base, used for residents who cannot press a traditional call light button. Observation of Resident #1's hands revealed they were contracted. Resident #1 said she can use the call light but did not know where it was. Resident #1 was only able to speak very softly.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation/interview on 3-20-2024, at 11:15 AM, it was revealed that it took RN A, 2 minutes to untangle Resident #1's pressure call light cord, behind the refrigerator in Resident #1's room, for the call light to be able to reach Resident #1's bed. After Resident #1's call light was put within reach of Resident #1, Resident #1 said she can use the call light and pressed the call light button with her elbow. RN A said the concern for Resident #1's call light not being within reach, is Resident #1 may need help and would not be able to contact staff.</p> <p>In an interview with CNA B, on 3-20-2024, at 3:00 PM, indicated Resident #1 is very dependent on staff and Resident #1 cannot do anything for herself. Resident #1 has a pressure call light button which gave the benefit of Resident #1 to be able to activate the button by touching it with any part of Resident #1's body. CNA B stated it is bad for Resident #1 if her call light button was not within reach as she cannot get the help she would need.</p> <p>In an interview with ADON, on 3-20-2024, at 3:15 PM, revealed that a call light, not being within reach for a resident, can cause - skin breakdowns, increased anxiety, all the way to the worst-case scenario. It can be a danger to the resident.</p> <p>In an interview with the DON, on 3-21-2024, at 1:57 PM, revealed that if Resident #1's call light was way over by the refrigerator, Resident #1 could not reach it. The DON stated that the danger was the resident could fall, have medical problems, and they cannot communicate with staff. The DON stated it is everyone's responsibility, working on Resident #1's hall, to check on Resident #1 as much as they can. The DON stated her expectation was that call lights always be within reach of every resident.</p> <p>In an interview with the Administrator, on 3-21-2024, at 12:51 PM, indicated Resident #1 had a pressure call light. The Administrator stated the main issue, in the self-report, filed on 10-6-2023, by Resident #1's family, was that they felt Resident #1 was being neglected because of the long call light response time. The Administrator said if Resident #1's pressure call light pad, was out of reach on the refrigerator, it was a problem and needs to be within reach. The concern was that in the event Resident #1 needed something, Resident #1 would not be able to communicate with staff. The Administrator stated it was responsibility of the nurses and nurse leadership to ensure call lights are within reach of residents. The Administrator stated all residents' call lights should be within reach, but it was more critical that residents with ADL assistance needs have theirs within reach.</p> <p>Record review of Resident #1's care plan, dated 2-8-2024, indicated Resident #1 is at risk for SOB, and may need immediate assistance from staff.</p> <p>Resident #20</p> <p>Record review of Resident #20's admission record, dated 03/21/2024, reflected an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included dysarthria following other cerebrovascular disease, vascular dementia, and Alzheimer's Disease.</p> <p>Record review of Resident #20's quarterly MDS, dated [DATE], reflected a BIMS score of 6, indicating severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #20's care plan, initiated on 07/29/2021 and revised on 08/09/2023, revealed Resident #20 was at risk for Falls r/t lower extremity weakness with interventions that included encourage use of call light and keep call light within reach at all times when in room.</p> <p>Observation on 03/20/2024 at 10:59 AM revealed Resident #20's call light behind her refrigerator.</p> <p>Observation and interview on 03/21/2024 at 10:23 AM revealed Resident #20's call light placed on top of the refrigerator. Resident #20 could not reach the call light and stated she does not push the call button that often. Resident #20 stated she would call out for help if she could not reach it.</p> <p>Observation and interview on 03/21/2024 at 10:48 AM revealed CNA C clipped Resident #20's call light to the sheet next to the resident and stated they usually put it there. He stated they just check on her every 2 hours. CNA C stated Resident #21 uses the call light and will ask to have the call light in reach. CNA C stated mostly everyone, but CNA's that do direct care were responsible to put the call light in reach so the resident can call anytime they need help.</p> <p>Resident #21</p> <p>Record review of Resident #21's admission record, dated 03/21/2024, reflected a [AGE] year-old male who admitted on [DATE] with diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.</p> <p>Record review of Resident #21's quarterly MDS, dated [DATE], reflected a BIMS of 5, indicating severe cognitive impairment.</p> <p>Record review of Resident #21's care plan, initiated on 10/21/2021 and revised on 08/11/2023, revealed Resident #21 was at risk for falls r/t impaired mobility/gait instability/incontinence with an intervention that included ensure call light is within reach, educate him on call light system and encourage use of call light.</p> <p>Observation on 03/20/2024 at 11:19 AM revealed Resident #21's call light on the dresser was out of reach.</p> <p>Observation and interview on 03/21/2024 at 10:27 AM revealed Resident #21 lying in bed with the call light over his lap. Resident #21 stated he was able to push the light if he needed help. He stated they usually put the light on the bedrail and pointed to the rail on his right. Resident #21 was not able to lift his shoulder and reach over to the bedrail. He stated he will call out Nurse when they walk by, but it did not do any good.</p> <p>Interview on 03/21/2024 at 12:45 PM LVN B stated resident call lights should be at their bedside or next to them if they were sitting in the room. She stated CNA's, MA's and Nurses were responsible for making sure the call light was in reach and if not in reach, residents could fall if they try to get out of bed or reach for something.</p> <p>Record review of the facility's Call Light Policy, dated 9-2022, stated:</p> <p>Purpose</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The purpose of this procedure is to ensure timely responses to the resident's requests and needs.</p> <p>General Guidelines</p> <ol style="list-style-type: none"> <li>1. Upon admission and periodically as needed, explain and demonstrate use of the call light to the resident.</li> <li>2. Ask the resident to return the demonstration.</li> <li>3. Explain to the resident that a call system is also located in his/her bathroom.</li> <li>4. Be sure that the call light is plugged in and functioning at all times.</li> <li>5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.</li> <li>6. Report all defective call lights to the nurse supervisor promptly.</li> </ol> <p>Steps in the Procedure</p> <ol style="list-style-type: none"> <li>1. Answer the resident call system immediately. When answering an auditory request for assistance, identify yourself and politely respond to the resident by his/her name (e.g., This is Mrs. [NAME]. Mr. [NAME], how may I help you?).               <ol style="list-style-type: none"> <li>a. If the resident needs assistance, indicate the approximate time it will take for you to respond.</li> <li>b. If the resident's request requires another staff member, notify the individual.</li> <li>c. If the resident's request is something you can fulfill, complete the task within five minutes if possible.</li> <li>d. If you are uncertain as to whether or not a request can be fulfilled, or if you cannot fulfill the resident's request, ask the nurse supervisor for assistance.</li> </ol> </li> <li>2. If assistance is needed when you enter the room, summon help by using the call signal.</li> <li>3. When answering a visual request for assistance (light above the room door), knock on the room door. When the resident responds, address the resident by his/her name (e.g., How may I help you, Mr. [NAME]?). Follow the prompts above.</li> </ol> <p>48177</p>