STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676036	A. Building B. Wing	03/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Ridge Nursing & Rehabilitation Center	700 E Vista Ridge Mall Dr Lewisville, TX 75067

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42283 Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection for two (CNA A and CNA B) of 8 CNAs reviewed for infection control. CNA A and CNA B failed to wear adequate PPE while repositioning COVID-19 positive Resident #1. CNA A failed to wear adequate PPE while delivering and setting up COVID-19 positive Resident #2's breakfast tray. CNA A and CNA B failed to perform hand hygiene while delivering and picking up breakfast trays from residents on the 300 hall. This failure placed residents at risk for infection and result in decline in health. The findings included: Review of Resident #1's quarterly MDS, dated [DATE], revealed she was an [AGE] year-old female who admitted to the facility on [DATE]. Her hearing, speech, and vision section revealed she usually made herself understood and usually understood others. Her BIMS score was 8 out of 15 which indicated moderate cognitive impairment. Her functional limitation in range of motion revealed she had lower extremity impairment on both sides and used a wheelchair. Her mobility revealed she required partial/moderate assistance to roll left and right. She required substantial/maximal assistance to sit to lay and laying to sitting on the side of her bed. Her diagnoses included anemia heart failure, hypertension, diabetes, hyponatremia, cerebrovascular accident, Non-Alzheimer's Dementia, hemiplegia , depression, asthma, and respiratory failure. Review of Resident #1's Care Plan, undated, revealed she had an ADL self-care performance deficit due to Dementia. Her goal was to continue receiving assistance from staff with all ADLs due to generalized weakness. Her interventions for bed mobility was to receive limited assistance by one staff. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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NAME OF PROVIDER OR SUPPLIER Vista Ridge Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 E Vista Ridge Mall Dr Lewisville, TX 75067	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's quarterly MDS, dated [DATE], revealed she was a [AGE] year-old female who admitted to the facility on [DATE]. Her BIMS score was 14 out of 15 which indicated she was cognitively intact. Her functional limitation in range of motion revealed she had an impairment on one side of her upper and lower extremities. Her functional abilities and goals self-care revealed she required supervision or touching assistance with eating. Her diagnoses included anemia, diabetes, hyperlipidemia, cerebrovascular accident, hemiplegia , and seizure disorder. Review of Resident #2's Care Plan, undated, revealed she had an ADL self-care performance deficit due to late effects of CVA with hemiplegia and left-hand splints were applied PRN. Her goal was to continue to require extensive staff assistance with ADLs. Her interventions with eating were assistance with meal tray set-up and cutting of meat. Review of Resident #3's quarterly MDS, dated [DATE], revealed she was a [AGE] year-old female who admitted to the facility on [DATE]. Her BIMS score was 10 out of 15 which indicated moderate cognitive impairment. Her functional abilities and goals self-care revealed she required partial/moderate assistance with eating. Her diagnoses included anemia, hypertension, Alzheimer's disease, seizure disorder, and glaucoma. Review of Resident #3's Care Plan, undated, revealed she had an ADL self-care performance deficit due to poor vision and memory deficit. Her goal was to improve her current level of ADLs. Her intervention with eating was set up help . Observation on 03/03/24 beginning at 8:15 AM revealed Resident #2 was on isolation precautions for COVID-19. There was signage on her door that informed visitors/staff she was on special droplet precautions, perform hand hygiene before and after leaving room, necessary PPE to wear in room, and donning/doffing (put on/remove) information. CNA A was observed entering Resident #2's room only wearing a N95 mask. While in the room CNA A delivered and set up Resident #2's breakfast tray. CNA A left Resident #2's room without performing hand hygiene. CNA A then went into the Kitchen to retrieve a glass of milk for Resident #2. CNA A re-entered Resident #2's room and only wearing a N95 mask. CNA A did not perform hand hygiene after delivering a glass of milk to Resident #2. Observation on 03/03/24 at 8:18 am revealed Resident #1 was on isolation precautions for COVID-19. There was signage on her door that informed visitors/staff she was on special droplet precautions, perform hand hygiene before and after leaving room, necessary PPE to wear in room, and donning/doffing information. CNA A entered Resident #1's room wearing a N95 mask and gloves. CNA B entered Resident #1's room wearing only a N95 mask. CNA A and CNA B physically repositioned Resident #1 in her bed. CNA A and CNA B did not perform hand hygiene after repositioning Resident #1. CNA B immediately entered non-covid positive Resident #3's room and set up her breakfast tray without performing hand hygiene. Observation on 03/03/24 beginning at 8:40 am revealed there were seven COVID-19 positive residents at the facility. There were PPE carts located outside COVID-19 positive resident's room. There was only two face shield and one gown located in the PPE cart on the 300 hall. The other halls throughout the facility had several face shields, gowns, and boxes of gloves in the PPE cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/03/24 beginning at 8:50 AM revealed CNA A went into COVID positive Resident #'s room only wearing a N95 mask to pick up breakfast trays. CNA A proceeded to pick up breakfast trays from COVID-19 positive and negative residents' rooms on the 300 hall without performing hand hygiene. Interview with the DON on 03/03/24 at 9:29 AM revealed the facility had eight COVID-19 positive residents and seven were in house. She stated all staff were aware of which residents at the facility were COVID-19 positive. She stated there was signage on the COVID-19 positive residents' doors regarding droplet/special precautions and the PPE needed to enter the room. She stated there were PPE carts with supplies located outside of the COVID-19 positive residents' rooms. She stated staff were required to wear N95 masks, gowns, face shields, and gloves when entering a COVID-19 positive resident's room. She stated staff were required to perform hand hygiene before and after providing care to residents. She stated the nurses were responsible for stocking the PPE carts on the hall because CNAs did not have access to where PPE was stored (central supply). The DON stated CNA A and CNA B should have worn a gown, gloves, and face shield while in COVID-19 positive rooms. She stated CNA A and CNA B should have performed hand hygiene before/after leaving residents' rooms, delivering breakfast trays, and picking up breakfast trays. She stated she and the ADON were responsible for training staff on infection control and hand hygiene. She stated the residents on the 300 hall were at risk of contracting COVID-19 due to the possible spread of COVID-19 from CNA A and CNA B. Interview with CNA A on 03/03/24 at 10:44 AM revealed she knew Resident #1 and Resident #2 were COVID-19 positive. She stated she only wore a N95 mask and gloves while repositioning Resident #1 in bed. She stated she only wore a N95 mask while delivering Resident #2's breakfast tray and milk. She stated she did not wear the necessary PPE for COVID-19 positive residents because there was no PPE located in the carts on the 300 hall. She stated she did not know who was responsible for stocking the PPE carts with supplies. She stated she did not inform the nurse there was no supplies in the PPE carts located outside of the COVID-19 positive residents' rooms. She stated she should have notified the nurse regarding the PPE shortage. She stated she was supposed to perform hand hygiene before and after entering a Resident #1's and Resident #2's room. She stated she was supposed to perform hand hygiene in between delivering and picking up 300 hall breakfast trays. She stated she was in-serviced regarding hand hygiene and infection control the week of 02/26/24. She stated the risk of not wearing PPE in COVID-19 positive residents' rooms was exposing herself and others to COVID-19. She stated the risk of not performing hand hygiene was spreading germs from one resident to another resident. Interview with CNA B on 03/03/24 at 11:03 am revealed she knew Resident #1 was COVID-19 positive. She stated she only wore a N95 mask to reposition Resident #1 in bed. She stated she was supposed to wear a face shield, gown, and gloves. She stated she did not wear a face shield, gown, or gloves because there were none located in the PPE carts outside of the COVID-19 positive residents' rooms. She stated she did not know who was responsible for stocking the PPE carts with supplies. She stated she did not inform the nurse there was no PPE located on the 300 hall. She stated there were no risks to the residents because face shields, gloves, and gowns were only worn as extra precautionary measures. She stated hand hygiene was supposed to be performed in between each resident. She stated hand hygiene was supposed to be performed in between each resident when delivering and picking up their breakfast trays. She stated she forgot to perform hand hygiene because she was focused on her tasks. She stated she was in-serviced regarding infection control and hand hygiene sometime during the month of February 2024. She stated the risk of not performing hand hygiene was possibly spreading an infection to every resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LVN C on 03/03/24 at 11:33 am revealed she was not informed by CNA A and CNA B that there were no gowns or face shields in the PPE carts located on the 300 hall. She stated the nurses were responsible for stocking the PPE carts. She stated she was unaware CNA A and CNA B were not wearing gowns, gloves, or face shields in COVID-19 positive resident rooms. She stated she was unaware CNA A and CNA B were not performing hand hygiene while delivering breakfast trays, picking up breakfast trays, and in between each resident. She stated she did not know who was responsible for ensuring CNAs were wearing PPE in COVID-19 positive residents' room and performing hand hygiene. She stated the risk of CNA A and CNA B not wearing proper PPE and performing hand hygiene could spread an infection. The facility's Infection Control policy was requested on 03/03/24 at 12:37 PM and not provided by the Administrator prior to exit. Review of the facility's list of COVID positives (undated) revealed there were seven COVID-19 positive residents at the facility including Resident #1 (02/22/24) and #2 (02/22/24). Interview with Resident #1 on 03/03/24 at 2:07 PM revealed she refused to speak with this surveyor. Interview with Resident #3 on 03/03/24 at 2:28 PM revealed CNA B came into her room to deliver and set up her breakfast tray. She stated she was unaware if CNA B performed hand hygiene. Interview with Resident #2 on 03/03/24 at 2:35 PM revealed she was COVID-19 positive. She stated CNA A came into her room to deliver and set up her breakfast tray. She stated sometimes staff did not wear gowns, gloves, or face shields while in her room. She stated she was unaware if staff performed hand hygiene. Review of the facility policy titled, Handwashing/Hand Hygiene, dated 10/2023 revealed, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Hand hygiene is indicated immediately before touching a resident, after touching a resident, after touching the resident's environment, and immediately after glove removal.