

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676036	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/16/2024
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	

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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</b></p> <p>Based on interviews and record review the facility failed to ensure the resident had the right to participate in the development and implementation of his person-centered plan of care for one (Resident #1) of five resident reviewed for person-centered plans of care.</p> <p>The facility failed to include Resident #1 in his Care Plan Conference.</p> <p>This failure could affect residents and place them at-risk by contributing to inadequate care.</p> <p>The findings included:</p> <p>Record review of Resident #1's electronic face sheet printed 4/16/2024 revealed an 86 -year-old male admitted on [DATE] and discharged on [DATE] with diagnoses that included to dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), chronic kidney disease stage 3 (mild to moderate loss of kidney functions), and benign prostatic hyperplasia with lower urinary tract symptoms(frequent or urgent need to urinate).</p> <p>Record review of Resident #1's quarterly MDS date 2/21/2024 revealed a BIMS score of 13 which indicated the resident was cognitively intact.</p> <p>Review of Resident #1's most recent care plan did not discuss Resident #1 being involved in the care plan.</p> <p>Record review of Resident #1's Care Conference meeting notes completed 02/15/2023 revealed the resident was not checked at being in attendance under the meeting attendance section.</p> <p>Interview on 04/16/2024 at 1:00PM with Resident #1 revealed he wanted to obtain a copy of his medication list because he felt he was taking too many medications. Resident #1 stated he also wanted to discuss his discharge plan with the facility. He stated that he informed the facility last year that he wanted to go to an assisted living and that he needed hearing aids. Resident #1 stated he had not been involved in a care plan meeting since last year to follow up on his concerns.</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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 04/16/2024 at 3:17PM with the Social Worker revealed that she thought the last care plan meeting was held sometime last year however she was not sure of the exact date. She stated Resident #1 was always involved in his care plan meetings and very involved in his care. She stated due to the facility changing systems in which resident records were uploaded, she was not able to access the last care plan conference. The Social worker stated Resident #1 had not had a care plan conference this year and she would be scheduling a care plan conference for him soon.</p> <p>Interview on 04/16/2024 at 3:50 PM with the DON revealed she was sure the resident had a care plan meeting this year however the were not able to access the records. The DON stated she remembered talking to the resident about his care this year however whether it was formally documented she was not sure.</p> <p>Interview on 04/16/2024 at 3:50 PM with the Administrator revealed due to the system change over that occurred around April 8th, 2024, they were not able to access previous resident records. She stated if a care plan conference was completed this year, they would not have access to it. The Administrator stated they were moving forward with trying to complete care plan this quarter due to not being able to access the ones completed prior to April 8th, 2024. The Administrator did not acknowledge any risk to residents due to not being able to access care plans.</p> <p>Review of the facility policy Care planning- interdisciplinary team revised January 21,2024 revealed in part The resident, the resident's family, and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan . Care Plan Review will be completed and signed by all attending persons using the Multi-Disciplinary Care Plan Conference Form or equivalent.</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>45268</p> <p>Based on observations, interviews, and record review the facility failed to protect the confidentiality of personal health care information for one (CMA B) of three staff observed for confidentiality of records.</p> <p>The facility failed to ensure CMA B locked and closed the laptop during the medication pass exposing all resident on the hall's personal information.</p> <p>This failure could affect residents by placing them at risk for loss of privacy and dignity.</p> <p>The findings included:</p> <p>Observation on 04/16/24 at 12:40PM revealed the computer on Medication Cart 1 was unlocked and unattended on Hall 300. The computer was unattended while CMA B was in a resident room for approximately two minutes. There were residents and a house keeper walking past the unlocked computer which displayed the residents on hall 300's name and medication due.</p> <p>Interview on 04/16/24 at 12:43PM with CMA B revealed she had worked the facility for 4 months. She stated she was aware the computer should have been locked however she went to help a resident that needed assistance in the restroom. She stated normally she would have locked the computer, but she forgot. She stated the risk of not locking the computer would be resident information would be accessible to others.</p> <p>Interview on 04/16/2024 at 3:50PM with the Administrator revealed computer screen on the medication cart were to be locked whenever not in sight. She stated the CMA that left the computer unlocked was pulled from the floor and in-serviced already. The Administrator stated the risk of leaving the computer unlocked would be that resident information could be accessed.</p> <p>Review of the facility policy Resident rights revised October 4,2022 revealed Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include privacy and confidentiality.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45268</b></p> <p>Based on observations, interviews, and record review, the facility failed to provide a sanitary environment for 1 (Residents #1) of 4 residents reviewed for environmental conditions.</p> <p>The facility failed to ensure Resident #1's bed was made with clean linens and was not wet and did not contain urine stains.</p> <p>The failure placed residents at risk for unsanitary living.</p> <p>Findings included:</p> <p>Record review of Resident #1's electronic face sheet printed 4/16/2024 revealed an 86 -year-old male admitted on [DATE] and discharged on [DATE] with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), chronic kidney disease stage 3 (mild to moderate loss of kidney functions), and benign prostatic hyperplasia with lower urinary tract symptoms (frequent or urgent need to urinate).</p> <p>Record review of Resident #1's quarterly MDS date 2/21/2024 revealed a BIMS score of 13 which indicated the resident was cognitively intact. Review of Section GG functional abilities and goal revealed moderate assistance with toileting. Review of Section H Bladder and bowel indicate frequent incontinence of urinary and bowel.</p> <p>Review of Resident #1's care plan revised 1/12/2024 revealed bowel and bladder incontinence with 1 person assist.</p> <p>Interview and observation on 04/16/2024 at 1:00PM with Resident #1 revealed a strong smell of urine in the room. Resident #1's bed sheet had a yellow circular stain. Resident #1 stated he wet his bed last night and the sheets had not been changed. Resident #1 stated the mattress was wet and the sheets were almost dry. Resident #1 stated the staff do not change his sheets and typically he had to wait for the bed and the sheets to dry before he was able to get in the bed. He stated housekeeping cleaned his room however they do not make his bed.</p> <p>Interview on 04/16/2024 at 2:34PM with CNA A revealed she was working the hall for Resident #1. She stated the linens should have been changed on the prior shift. She stated linens were changed on shower days or as needed. She stated she had just begun her shift and was not aware of Resident#1's linens needing to be changed.</p> <p>Interview on 04/16/2024 at 3:40PM with the Administrator revealed CNA's were responsible for changing the linens for residents on their shower days. She stated linens should also be changed if they were soiled. She stated the risk of linens not being changed when they were soiled would be risk of infection control or skin breakdown.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy Resident rights revised October 4, 2022 revealed, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45268</p> <p>Based on interviews and record reviews, the facility failed to ensure comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment, which included both the comprehensive and quarterly review assessments for 1 of 6 residents (Resident #1 reviewed for Care Plans.</p> <p>The facility failed to ensure Resident #1 Care Plan was reviewed and updated quarterly.</p> <p>This failure could place residents at risk of their needs not being met.</p> <p>Findings included:</p> <p>Record review of Resident #1's electronic face sheet printed 4/16/2024 revealed 86 -year-old male admitted on [DATE] and discharged on [DATE] with diagnosis that included but not limited to dementia(impaired ability to remember, think, or make decisions that interferes with doing everyday activities), chronic kidney disease stage 3(mild to moderate loss of kidney functions), benign prostatic hyperplasia with lower urinary tract symptoms(frequent or urgent need to urinate)</p> <p>Record review of Resident #1's quarterly MDS date 2/21/2024 revealed a BIMS score of 13 which indicated the resident was cognitively intact and Resident #1 required 1 person assist for activities of daily living assistance.</p> <p>Record review of Resident #1's Care Conference meeting notes completed 02/15/2023. There was not a care plan conference completed in 2024.</p> <p>Interview on 04/16/2024 at 1:00PM with Resident #1 revealed he wanted to obtain a copy of his medication list because he felt he was taking too many medications. Resident #1 stated he also wanted to discuss his discharge plan with the facility. He stated he informed the facility last year that he wanted to go to a assisted living and that he needed hearing aids. Resident #1 stated he had not been involved in a care plan meeting since last year to follow up on his concerns.</p> <p>Interview on 04/16/2024 at 3:17PM with the Social Worker revealed she thought the last care plan meeting was held sometime last year however she was not sure of the exact date. She stated Resident #1 was always involved in his care plan meetings and very involved in his care. She stated due to the facility changing systems in which resident records are uploaded she was not able to access the last care plan conference. The Social worker stated Resident #1 had not had a care plan conference this year and she would be scheduling a care plan conference for him soon.</p> <p>Interview on 04/16/2024 at 3:50 PM with the DON revealed she was sure the resident had a care plan meeting this year however the were not able to access the records. The DON stated she remembered talking to the resident about his care this year however whether it was formally documented she was not sure.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 04/16/2024 at 3:50 PM with the Administrator revealed due to the system change over that occurred around April 8th, 2024, they were not able to access previous resident records. She stated if a care plan conference was completed this year they would not have access to it. The Administrator stated they were moving forward with trying to complete care plan this quarter due to not being able to access the ones completed prior to April 8th, 2024. The Administrator did not acknowledge any risk to residents due o not being able to access care plans.</p> <p>Review of the facility policy Care planning- interdisciplinary team revised January 21,2024 revealed in part The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan . Care Plan Review will be completed and signed by all attending persons using the Multi-Disciplinary Care Plan Conference Form or equivalent.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>45268</p> <p>Based on observations, interviews, and record review, the facility failed to store all drugs and biologicals in locked compartments for one of four halls (Hall 300) reviewed for medication storage.</p> <p>On 4/16/2024, the facility failed to keep Medication Cart 1 locked on Hall 300.</p> <p>These failures placed 27 residents on Hall 300 at risk of drug diversions or misuse of medications.</p> <p>Findings included:</p> <p>Observation on 04/16/24 at 12:40PM revealed Medication Cart 1 was unlocked and unattended on Hall 300. All the drawers of Medication Cart 1 could be opened, and the medication was easily accessible due to the lock not being pushed in on the cart. The cart was unattended while CMA B was in a resident room for approximately two minutes. There were residents walking past the unlocked medication cart and a housekeeper on the hall working near the cart.</p> <p>Interview on 04/16/24 at 12:43PM with CMA B revealed she had worked the facility for 4 months. She stated she was aware the medication cart should have been locked; however, she went to help a resident that needed assistance in the restroom. She stated normally she would have locked the cart, but she forgot. She stated the risk of not locking the cart would be someone could access the medication.</p> <p>Interview on 04/16/2024 at 3:50PM with the Administrator revealed medication carts were to be locked whenever not in sight. She stated the CMA that left the medication cart unlocked was pulled from the floor and in-serviced already. The administrator stated the risk of leaving the medication cart unlocked was that someone could access the medication.</p> <p>Review of the facility policy Storage of Medication, revised April 2019 revealed Unlocked medication carts are not left unattended.</p>