

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 05/22/2024
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that residents, who needed respiratory care, was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for three (Resident #1, Resident #2, and Resident #3) of eight residents reviewed for quality of care.</p> <ol style="list-style-type: none"> The facility failed to ensure Resident #1's nasal cannula nasal cannula (flexible tube used to deliver oxygen to the nose through two prongs) was stored properly. The facility failed to ensure Resident #1's nasal cannula and humidifier were changed weekly. The facility failed to ensure there was an Oxygen in Use sign outside Resident #1's door. The facility failed to ensure Resident #2's nasal cannula was stored properly. The facility failed to ensure Resident #3's mask for BiPAP (bilevel positive airway pressure - normalizes breathing by delivering pressurized air into the upper airway leading into the lungs) was cleaned and stored properly. <p>These failures could place the residents at risk for respiratory infection and not having their respiratory needs met.</p> <p>Findings included:</p> <p>Resident #1</p> <p>Review of Resident #1's Face Sheet, dated 05/22/2024, reflected that the resident was an [AGE] year-old male admitted on [DATE]. One of the relevant diagnoses included chronic pulmonary embolism (blockage in the artery of the lungs that stops blood flow).</p> <p>Review of Resident #1's Quarterly MDS Assessment, dated 04/22/2024, reflected resident had a severe impairment in cognition with a BIMS score of 04.</p> <p>Review of Resident 1's Comprehensive Care Plan, dated 05/19/2024, reflected resident had oxygen therapy related to shortness of breath and one of the interventions was interventions was oxygen via nasal prongs at 2 liters per minute as needed.</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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 1's Physician Order, dated 05/07/2024, reflected O2 @ 2L as needed only if O2% is lower than 92% every 24 hours as needed.</p> <p>Review of Resident 1's Physician Order, dated 05/22/2024, reflected Oxygen: O2 tubing and water bottle q Sunday night every night shift every Sun weekly.</p> <p>Observation and interview with Resident #1 on 05/22/2024 at 7:38 AM, revealed Resident #1 was on his bed awake. Resident #1 had an oxygen concentrator at bedside. One end of the nasal cannula was attached to the oxygen concentrator while the other end was coiled on the grab bars of the resident's bed. It was also observed that the date of the nasal cannula and the humidifier were dated 05/12/2024. Resident #1 stated he was on oxygen because he had respiratory issues but said he used oxygen at night most of the time. He said he was not aware if the nurses were changing his nasal cannula and the bottle with water. The resident also said he never saw a plastic bag for the nasal cannula. It was also noted that there was no Oxygen in Use outside the resident's door.</p> <p>Observation and interview with the ADON on 05/22/2024 at 10:25 AM, the ADON stated there should be an Oxygen in Use sign outside the door of the residents who were on oxygen therapy to make sure appropriate precautions were followed. She said which ever staff that received the order for oxygen use should had put the sign outside the door. She also acknowledged that the nasal cannula was not bagged. She said it should be bagged when not in use to prevent contamination. The ADON looked for the bag behind the concentrator and inside the drawer of the bedside table and said there was no bag available. The ADON then checked the dates on the tubing of the nasal cannula and on the humidifier. She said both were dated 05/12/2024 and said the date should be 05/19/2024. She said the nasal cannula and the humidifier should be changed weekly to prevent infection and not to compromise the resident's breathing pattern. She said the expectation was for the staff to make sure the nasal cannula was bagged when not in use and to change the nasal cannula and the humidifier weekly and to put a date on it. The ADON disconnected the nasal cannula and the humidifier and said she would change them. She said she would also get an Oxygen in Use sign and place it outside the door.</p> <p>Resident #2</p> <p>Review of Resident #2's Face Sheet, dated 05/23/2024, reflected that the resident was a [AGE] year-old female admitted on [DATE]. One of the relevant diagnoses was chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) .</p> <p>Review of Resident #2's Quarterly MDS Assessment, dated 05/04/2024, reflected that Resident #2 was cognitively intact with a BIMS score of 14. The Quarterly MDS also indicated that the resident was on oxygen therapy.</p> <p>Review of Resident #2's Comprehensive Care Plan dated 05/21/2024 reflected resident had oxygen therapy at 2 liter per minute (prn) via nasal cannula for SOB one of the interventions was OXYGEN SETTINGS: O2 via nasal cannula @ 2 LPM (prn).</p> <p>Review of Resident #2's Physician Order dated 10/25/2023 reflected, O2 @ 2L/Min via NC PRN to maintain O2 sats > 90% every shift.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and interview with Resident #2 on 05/22/2024 at 9:02 AM, revealed Resident #2 was in her wheelchair. It was noted that she had a nasal cannula attached to an oxygen concentrator. The prongs of the nasal cannula were on the bed. The nasal cannula was not bagged. She stated she only used her oxygen at night. She said the staff never gave her a bag for the nasal cannula. She said she was not aware the nasal cannula should not be left anywhere. She said it makes sense that the nasal cannula be bagged so it will not be dirty.</p> <p>Resident #3</p> <p>Review of Resident #3's Face Sheet, dated 05/21/2024, reflected that the resident was a [AGE] year-old female admitted on [DATE]. One of the relevant diagnoses was sleep apnea (a sleep disorder where breathing is interrupted repeatedly during sleep).</p> <p>Review of Resident #3's Quarterly MDS Assessment, dated 05/04/2024, reflected that Resident #3 had moderate impairment in cognition with a BIMS score of 09. The Quarterly MDS also indicated that the resident was on BiPAP (bilevel positive airway pressure - normalizes breathing by delivering pressurized air into the upper airway leading into the lungs).</p> <p>Review of Resident #3's Comprehensive Care Plan, dated 03/14/2024, reflected resident had altered respiratory status/difficulty breathing r/t Sleep Apnea and was on BIPAP as ordered ON Q HS AND OFF IN AM.</p> <p>Review of Resident #3's Physician Order dated 10/16/2023 reflected, BIPAP ON Q HS OFF AT AM at bedtime related to SLEEP APNEA.</p> <p>Observation and interview with Resident #3 on 05/22/2024 at 9:10 AM, revealed Resident #3 was awake. It was noted that there was a BiPAP machine on top of the resident's side table with its connecting tube inside the drawer of the side table. A BiPAP mask was connected to the tube, the mask was not bagged. The mask also had three small and hard white substance She stated she used her BiPAP at night but sometimes she would refuse to wear it because it was so noisy. She said the staff would put it on and take it off. She said she was not aware if the staff would put it on a bag after taking it off.</p> <p>Observation and interview with RN A on 05/22/2024 at 10:17 AM, RN A stated the resident used a BiPAP at night. RN A opened the drawer and acknowledged the BiPAP mask was not bagged. She also saw the plague on the BiPAP mask of the resident. She stated it should be bagged to prevent contamination and potential infection. She said she would clean the mask and then put it in a plastic bag. She said she would check if there was a new mask and would replace the BiPAP mask.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview with the Administrator on 05/022/24 at 10:55 AM, the Administrator stated the humidifier and the nasal cannula should be changed every week as per order. She added the mask for the BiPAP should be bagged as well. The Administrator said not bagging the nasal cannula and the BiPAP mask could lead to contamination and infection. She said the nasal cannula and the humidifier were changed weekly to prevent the growth of microorganism that could compromise the lungs of the residents. She said there should be an Oxygen in Use sign outside the room of the residents using oxygen to prevent any incident of fire. She said the expectation was for the staff to change the humidifier and the nasal cannula weekly and to bag the nasal cannula and the BiPAP mask. She concluded that they would do an in-service about respiratory care to remind them to change the humidifier and the nasal cannula weekly and to put the nasal cannula and the BiPAP mask in a bag when not in use.</p> <p>In an interview with the DON on 05/22/24 at 11:40 AM, the DON stated the humidifier and the nasal cannula should be changed weekly because the moisture in the humidifier and the nasal cannula were susceptible for mold growth. She said the nasal cannula and the mask should be bagged when not in use to prevent contact with dirty surfaces. She added the mask should be cleaned before putting it inside the plastic bag. She also said there should be sign outside the door for oxygen use as a precautionary measure. She said the sign was to remind the staff and the visitors that oxygen was being used in the building and any minimal spark could cause fire and explosion. The DON said all the staff were equally responsible in checking if the humidifier and the nasal cannula were changed weekly and if the nasal cannula and the mask were bagged when not in use. She said the expectation was for the staff to bag the BiPAP mask and the nasal cannula and to change the nasal cannula and the humidifier weekly. She also said another expectation would be a sign would be placed outside the door for oxygen use. She said they would do an in-service about respiratory care with the nurses and the CNAs.</p> <p>In an interview with LVN B on 05/22/2024 at 2:20 PM, LVN B said she put on Resident #3's BiPAP mask at night if the resident allowed her. She said she would usually get the BiPAP mask from the drawer of the side table. She said the mask was not bagged in the drawer. She said it should be cleaned and bagged after every use to prevent any respiratory infection.</p> <p>Record review of facility's policy, Oxygen Administration 2001 MED-PASS, Inc. rev. October 2010 revealed Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration . Steps in the Procedure . 2. Place an Oxygen in Use sign in a designated place outside resident room.</p> <p>Record review of facility's policy, Departmental (Respiratory Therapy) - Prevention of Infection 2001 MED-PASS, Inc. rev. November 2011 revealed Purpose: The purpose of this procedure is to guide prevention of infection . Steps in the Procedure . 3. [NAME] bottle with date . 7. Change the oxygen cannulae and tubing every seven (7) days, or as needed . 8. Keep the oxygen cannulae and tubing used PRN in a plastic bag when not in use.</p> <p>Record review of facility's policy, CPAP (continuous positive airway pressure: machine used to deliver pressurized air through a mask to keep airways open)/BiPAP Support 2001 MED-PASS, Inc. rev. March 2015 revealed Purpose: 1. To provide the spontaneously breathing . General Guidelines for Cleaning . 7. Masks . Rinse with warm water . between uses.</p>		