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	04/02/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for one (Resident #1) of five residents reviewed supervision. The facility failed to ensure Resident #1 (who was ordered a pureed diet and was a known aspiration risk) was provided with adequate supervision during the lunch meal on 04/01/25. Resident #1 was sat at a table with another resident who offered her a cookie, which Resident #1 accepted and ate, which led to her coughing several times before finishing the cookie. Five staff were in the dining room but no one was supervising the resident at the time to ensure safety or noticed she was eating outside her modified diet texture. An IJ was identified on 04/01/25 at 4:55 PM. The IJ template was provided to the facility on [DATE] at 4:57 PM. While the IJ was removed on 04/02/25, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and at a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place. The failures placed residents at risk of harm, including aspiration, choking and possible death. Findings included: Record review of Resident #1's Face Sheet dated 04/01/25 revealed she was a [AGE] year-old female who admitted to the facility on [DATE]. Her active diagnoses included pneumonia (an infection in the lungs caused by bacteria, viruses or fungi), functional dyspepsia (a chronic condition characterized by persistent discomfort or pain in the upper abdomen, without an underlying organic cause), aphasia (a language disorder that affects a person's ability to communicate), cerebral palsy (a neurological condition that affects movement, posture, and muscle control), severe intellectual disabilities. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 01, which indicated severe cognitive impairment. Resident #1 had no symptoms of psychosis, verbal/physical behaviors or rejection of care. She required partial/moderate assistance of staff with eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed). Resident #1 was on a mechanically altered diet and received speech therapy. (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

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	04/02/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's care plan initiated 08/30/24 reflected she had the potential for a nutritional problem related to a pureed texture. The care plan also reflected under the focus area that on 03/30/24 she was noncompliant with her pureed diet and would grab sandwiches from the snack cart. On 05/29/24, the care plan reflected she continued to grab sandwiches off the snack cart and would not let staff take it. Interventions included to provide and serve diet as ordered, monitor intake and record every meal. Resident #1 also had a care planned focus area which indicated she had an ADL self-care deficit related to dementia. Interventions reflected, Resident requires assistance with eating. Record review of Resident #1's CNA Kardex (the facility's CNA care plan-not dated) in the e-chart reflected Resident #1 required assistance with eating. Record review of a physician's order for Resident #1 dated 09/20/24 reflected a regular/enhanced diet with pureed texture. An interview with Resident #1 was attempted on 04/01/25 at 12:10 PM and revealed she was not interviewable. When asked questions, she just smiled and laughed. Record review of Resident #2's Face Sheet (dated 04/11/25) reflected she was an [AGE] year old female who admitted to the facility on [DATE] with active diagnoses of dementia (a syndrome that can be caused by a number of diseases which over time destroy nerve cells and damage the brain), Parkinsonism (a clinical syndrome characterized by movement disorders similar to those seen in Parkinson's disease) and schizoaffective disorder-bipolar type (a mental health condition characterized by symptoms of both schizophrenia and bipolar disorder, specifically involving periods of mania or hypomania alongside depressive episodes, along with psychotic symptoms like hallucinations and delusions). Record review of Resident #2's April 2025 MAR reflected she was ordered regular enhanced diet with regular texture (start date 09/13/24). Record review of Resident #2's care plan dated 08/26/24 reflected, Focus: The resident has impaired cognitive function impaired thought processes related to dementia .Intervention: Cue, re-orient and supervise as needed. (continued on next page)

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	04/02/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An observation on 04/01/25 at 12:28 PM revealed the LVN A was at the lunch service and was checking and verifying the meal tickets on the trays coming out of the kitchen. Resident #1's meal ticket was observed to be correct with a pureed textured, however, the kitchen staff failed to place a pureed bowl of cookie on her tray, which was listed as the dessert of the day. Resident #1's tray was checked by LVN A and taken to the resident. Resident #1 was sitting at a table with Resident #2. No staff were observed to sit with Resident #1 or assist her to eat. She was able to feed herself using utensils and was able to drink from a cup independently. She was not observed to cough or struggle with eating and appeared to have a strong appetite. At the same time, the resident sitting at the table with her (Resident #2) did not like her meal and wanted a baked potato. The facility staff removed Resident #2's tray but left the sugar cookie and brought her a baked potato which she did not like either and picked at it, eating only a few bites. During this time, Resident #2 was observed to offer bites of food on her spoon to various staff that walked by her table. Some staff were observed to encourage Resident #2 to eat it herself, but she continued to try and give it away. At one point, Resident #2 was eating her cookie and then stopped and held it out towards Resident #1. Resident #1 immediately took the cookie and at a bite and started coughing. When that occurred, there were three staff who had been at a table next to her (assisted feeding table) who did not notice she had taken Resident #2's cookie and was eating it and coughing. Resident #1 then took several drinks of her juice and cleared the impediment. Then she continued eating the cookie. At that moment, SDC D walked over to the table to check on the other resident because she was not eating (Resident #2) and was talking to her. While SDC D was at the table, she was observed to glance at Resident #1, who still had her hand up to her mouth with the cookie but did not intervene to remove it. LVN A was not present due to going back and forth into the kitchen to assist resident food requests. Resident #1 finished eating the cookie and her meal. She did not have any other coughing episodes during the meal. An interview with SDC D on 04/01/25 at 12:30 PM revealed her job in the dining room was to collect tickets, monitor the residents' intake and write it on the tickets. She said she did not notice Resident #1 was eating Resident #2's cookie and had she realized it, she would have politely removed it and gotten her a pureed cookie. An interview with LVN A on 04/01/25 at 12:31 PM revealed his job was to check meal tickets at the time of the meal being serves and all the staff in the dining room were supposed to watch and monitor/supervise the residents. He stated Resident #1 was not supposed to have anything other than pureed because she could choke and aspirate if she did. LVN A did not know why her pureed cookie was not provided to her on her tray and brought it to her which she was observed to eat 100%. LVN A stated Resident #1 had never aspirated before. Review of the following progress notes related to Resident #1's previous aspiration episode reflected: -A nursing progress note dated 01/9/25 the nurse practitioner was made aware of Resident #1 continuously coughing after lunch, her chest sounds were wet and congested. A stat chest x-ray was ordered and showed Resident #1 had left lung opacities (a white spot on the lung with uncertain significance) which could be due to atelectasis (the collapse of a lung) or pneumonia. Resident #1 was placed on antibiotic, nebulizer treatments, probiotics and cough/congestion medication for the next two 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
	676036	A. Building B. Wing	04/02/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-An infectious disease physician consultation note dated 01/12/25 reflected Resident #1 had a history of oropharyngeal dysphagia (a medical condition characterized by difficulty in swallowing due to issues in the oropharynx, which is the part of the throat located behind the mouth) and recent pneumonia as her recent chest x-ray showed opacities to the left lower base. The physician noted Resident #1 had a history of oropharyngeal dysphagia, history of cerebral palsy, a severe intellectual disability and cognitive and communication deficit. An interview with the DON on 04/01/25 at 12:40 PM she was notified about the incident with Resident #1 not being supervised during lunch. The DON stated there was no set number of staff that needed to be physically present in the facility's dining room, it just depended on how many residents were eating in dining room and needed assistance versus in their rooms. For the lunch meal service on 04/01/25, she stated LVN A and the new ADON were assigned to the dining room to supervise and check meal tickets, but it was the responsibility of all staff present to observe residents to ensure they were eating the correct diet texture/consistency. The DON stated she had a plan to implement a seating chart where residents who needed to be assisted would be placed at certain tables so it would be easier for PRN staff and newer staff to know those residents needed additional assistance and supervision. However, the DON stated she had not implemented that seating system yet. An interview with the SLP on 04/01/25 at 1:25 PM revealed both Resident #1 and Resident #2 were not supposed to be seated together as they were both cognitively impaired. The SLP stated Resident #1's diet texture was pureed and she had tried mechanical soft in past evals, but the resident would cough, so the SLP did not want to upgrade her diet as a result. She stated Resident #1 was in a wheelchair and could self-propel and wanted to eat anything that was out for residents, but due to her cognition, the staff had to take food away from her when she grabbed it from the snack cart or nurse station. The SLP stated, I educated staff about her pureed diet and how they are supposed to divert her or take her away, but that is her behavior unless she is a one on one. The SLP stated Resident #1's swallowing ability was not consistent, but because she had aspiration pneumonia before, a dry sugar cookie could cause her to have that happen again. She stated if Resident #1 ate a non-pureed food, such as the cookie, it could go down into her lungs if she could not clear if by coughing. Once it went down into her lungs, it could cause an infection such as pneumonia. The SLP stated one cookie would be enough to cause Resident #1 to aspirate. If it occurred, the SLP stated the resident may start turning blue and be struggling to breathe. She stated, But she should be fine now if she coughed and cleared it (the cookie). If someone gets into that situation, we usually call for the nurse or we can do the Heimlich manually. The SLP stated Resident #1 was currently on speech services to maintain her current functioning level. She stated, There is nothing to be improved because we tried everything, so when we see her, we try trials and cueing. The SLP stated Resident #1 did not have a waiver for pleasure feeds outside a pureed texture. She stated when that type of waiver was used, the responsible party would have to sign and acknowledge they understood the risks it posed to the resident. Once that was signed, the SLP stated the resident could then have whatever they wanted and in whatever consistency they liked. She stated Resident #1 did not have such a waiver. Record review of Resident #1's Speech Therapy Progress Report dated 02/20/25 through 03/18/25 reflected diagnoses of dementia and dysphagia. The goals Resident #1 was working on included, 1) Pt will demonstrate safe and functional swallow on LRD [least restrictive diet] utilizing safe swallow strategies and compensatory strategies maintaining safety without any overt s/s of aspirations. (continued on next page)

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	04/02/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with the ADM on 04/01/25 at 2:50 PM revealed Resident #1 was known to take food that she should not be eating and that the family had been notified of what happened earlier (04/01/25 at lunch) and they were going to be asked if they want to have a diet waiver signed since this is something she will continue doing. The ADM said she asked the SLP why a waiver was not tried prior, but the SLP had no answer for her. The ADM stated they were going to try to have residents sitting at tables based on their diet texture/supervision needs, so they could be supervised easier. An interview with CNA B on 04/01/25 at 3:05 PM revealed Resident #1 should not have been seated at a table with any resident that had a regular tray. CNA B stated, She [Resident #1] has a condition, maybe autism, that makes her always reach out to grab things. CNA B stated she asked the three staff who were at the assisted feeding table why Resident #1 was not sat with them. Their response was that Resident #1 was not a resident who needed to be fed and it was the therapy team who brought Resident #1 into the dining room late for lunch and placed her at the table with Resident #2. CNA B stated, Even though they don't have to feed her, she is supposed to be assisted and that is the table it happens at. If her care plan is saying she needs to be watched, then she needs to be at a table with a CNA. CNA B stated if Resident #1 did not get a bowl of pureed cookie on her lunch tray for herself, that was probably why she was eager to eat the one that Resident #2 gave her, because she likes the taste of sweets. CNA B stated she used to work as the staff development coordinator before she went PRN so she knew that SDC D's job was to ensure staff were trained and during the meal timesmealtimes. The SDC was responsible for looking at meal tickets, ensuring the residents were eating the correct meals, provide supervision and observation. CNA B stated on 04/01/25 she was assigned to work the halls for lunch even though she was assigned as Resident #1's CNA that morning shift, so she was not in the dining room. CNA B stated Resident #1 should have been taken to the table of residents who needed to be fed/assisted. CNA B stated she was told by various staff that there were too many staff working in the dining room on 04/01/25 during lunch due to HHSC investigator's observation of lunch and it was chaotic and stressful because of the amount of staff in there, which was not the norm. CNA B stated maybe if the facility would not have tried to put that many staff in the dining room who were not normally there, maybe the incident with Resident #1 would not have happened. She stated the facility should have let routine staff who were normally assigned in the dining room for lunch do their job they way they normally did, and possibly the incident would not have happened. A confidential interview on 04/01/25 at 7:30 PM revealed there had been numerous concerns voiced to the facility staff about Resident #1 being on a pureed diet, but still taking snacks of the snack cart or sandwiches that were kept at the nurse station that she could not eat safely. The individual stated they had observed Resident #1 take food that was not pureed, such as an apple, bite into it and then spit it out. Resident #1 would also open cracker packages from the snack cart as well and staff had to be vigilant to intervene before she could eat it. The individual stated the nurses were aware and tried to redirect, but they were not being provided any pureed snacks to give Resident #1 as an alternative. The individual stated they had tried to communicate the concern to staff because Resident #1 was known to be noncompliant with the diet due to her cognition and limited understanding of the safety risks. The individual stated a waiver had previously been discussed with the facility but they did not have one, even though Resident #1 was clearly eating things she could not have and she was aspirating and could not be watched her all the time. The individual felt Resident #1's life had been put in danger as a result of the facility staff not supervising her more closely with her food intake. (continued on next page)

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	04/02/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with the C-RN on 04/01/25 at 6:09 PM revealed Resident #1's family had been contacted about the incident and they stated going forward, they did not want to limit what she ate because she was in her 90s. As a result they agreed to sign a diet waiver. Review of the facility's policy titled, Therapeutic Diets, revised October 2017 reflected, Therapeutic diets are prescribed by the Attending Physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences . 4. A 'therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet, for example .Altered consistency diet. The facility ADM was asked for a policy on Accidents/Hazard on 04/02/25 at 3:05 PM but did not have one specific to that topic. An Immediate Jeopardy (IJ) situation was identified on 04/01/25 at 4:55 PM. The IJ template was provided to the facility's ADM on 04/01/25 at 4:57 PM. The following plan of removal submitted by the facility was accepted on 04/02/25 at 2:36 PM and reflected: [Facility name] Tuesday April 1, 2025 Res identified was immediately assessed by nursing and doctor and family were notified. New orders were given for a Stat chest x-ray, family requested them to pls let their [Resident #1] have what she wants as she is [AGE] years old. Family aware of risks April 1, 2025 and waiver requested and signed 4/1/25. All res have the potential to be affected by this deficient practice Diets reviewed to ensure accuracy; no other res were identified as taking food off tray. Snacks were removed from accessibility, for all res. Snacks will be available to nutrition area for availability. April 1, 2025. Staff in service on o Monitoring res while in dining room during meal service to ensure ALL res are not sharing food April 1 initiated o Observe res for any coughing, runny nose, any signs of distress while they are eating notify Nurse immediately o Res who offers their food attempting to give it away could be at risk for giving to another res staff are to take the snack who should not have it. o Snacks will be located in the nutrition room and offered to res Q shift o Supervision of res while in dining room to provide adequate supervision if a nurse must notify other personnel prior to exiting DON/ Designee in serviced 4/2/25. (continued on next page)

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	04/02/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Tables allocated for res who are identified that need/identified at risk assistance and supervision, April 1, 2025. And allocated by IDT team. o Supervision assignments for Dining room, reviewed and re-educated in-service April 2, 2025. o All mechanical diets were reviewed for compliance, completed by DON and Dietary manager 4/1/25. o Diet waivers will be continue to be on 24 hour report, for nursing identification, it was added to special instructions as well added to the tray card staff in served completed 4/2/25. Administrator and DON/ Designee will monitor, compliance and do random checks no less than weekly of dining room and process. Areas noted of concern will be added to QAPI to monthly X6 months. Monitoring: An interview with LVN A on 04/02/25 at 10:25 AM revealed he was the nurse assigned to the dining room for lunch on 04/01/25. He stated having a nurse present for meals was helpful to prevent any incidents with choking or any diet miscommunications. LVN A stated the residents with a pureed diet would have that indicated on their meal ticket coming from the kitchen. LVN A stated on 04/01/25, he remembered that Resident #1 had been in therapy and then they brought her into the dining room and placed her next to Resident #2, but going forward they were going to have assigned seating where staff could watch over her. LVN A stated out of the residents that were on pureed diets, Resident #1 was the only one that had the behavior of taking food off other residents' trays. An interview with SDC D on 04/02/25 at 11:38 AM revealed a resident was ordered a pureed diet but ate a non-pureed food could aspirate. SDC D stated it was important to supervise residents during mealtimes in the dining room to ensure there were no episode of choking. If a resident on a pureed diet was trying to eat another resident's food, she stated they cannot share so she would explain and separate them, especially if they had dementia and could not understand. Record review of a chest x-ray completed for Resident #1 on 04/01/25 at 6:48 PM revealed her lungs were clear and well inflated bilaterally and there was no evidence of acute pulmonary issues. Record review of Resident #1 and Resident #2's care plans reflected they were updated to reflect their increased need for supervision. A monitoring observation of the lunch meal service on 04/02/25 at 12:00 PM revealed the facility had re-arranged the dining room where three tables were lined up in a row for the residents who needed to be fed or assisted. At the table were four residents who were being fed by four staff. At the table also sat Resident #1, with a pureed meal tray. The SLP was nearby observing the Resident #1 as well as the other staff at the table. The resident ate her pureed meal without incident, although she continued to cough a few times while eating, she was able to clear the food from her throat and swallow it. Observation of Resident #1's revised meal ticket on 04/02/25 at 12:05 PM revealed under special notes, ***Assistant Dining***Waiver***Pleasure Feeding*** and it was highlighted in yellow. Her meal ticket continued to reflect a pureed diet at the top. (continued on next page)

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	04/02/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's diet waiver titled, Acknowledgement for Recommended Treatment Plan for Dietary dated 04/01/25 after the IJ was identified, reflected the resident's RP was declining the recommended treatment for a dysphagia diet of pureed. The DON, ADM, rehab therapist, and doctor all signed the form as well as the RP. Record review of the facility in-services were reviewed on 04/02/25 and reflected the staff were in-serviced on new supervision requirements for residents who need assistance, to be fed, or to be monitored for safety issue. The facility also provided three videos that reflected training on the Heimlich maneuver, signs and symptoms of choking and how to enter resident diet orders into the online e-chart. The facility also in-services staff on the new location of snack carts, protocol for dining room supervision, protocol for notifying the nurse in the dining room during meals, diet waiver protocol and implementation, Resident #1's supervision needs and diet texture and general supervision requirements for residents during meals in the dining room. Monitoring interviews for the Immediate Jeopardy were completed on 04/02/25 with 16 staff from 10:00 AM through 2:00 PM on all shifts to include: ADM, DON, LVN A, CNA B, SDC D, DM E, C-RN, AD, MA F, PT G, RN H, CNA I, LVN J, AIT, CNA K and CNA L. All staff interviewed were able to provide competency of supervision requirements in the dining room, new protocol for assisted feeding/supervision table, signs/symptoms of aspiration and choking and interventions and how to implement waiver request for special diets and know when a resident had one. The staff also demonstrated understanding of the facility's policy of the Heimlich maneuver, restrictions on resident food sharing, and new location of snacks and protocols for snacks for residents with a pureed diet. An interview with the DON on 04/02/25 at 2:50 PM revealed the facility received an IJ due to the staff not seeing Resident #1 eat a non-pureed item in the dining room as well as not supervising her when she was care planned to be observed. The DON stated a resident who was ordered a pureed diet and ate non-pureed food could aspirate, choke and die. The DON stated it was important to supervise residents during mealtimes in the dining room because they depended on the staff, were sometimes forgetful and do not always know what is right for them, So we are their eyes and care for them. The DON stated going forward, she would be monitoring how the dining room was running and ensure the schedule was followed with a nurse present during all meals, and any issues noted would be addressed in the daily management stand up meetings. (continued on next page)

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	04/02/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with the ADM on 04/02/25 at 3:04 PM revealed the facility received an IJ due to staff not observing Resident #1 eat a cookie in the dining room when she was supposed to have a pureed diet. She stated going forward with the new waiver in place, Resident #1 would be allowed to have pleasure feedings of regular texture if she or her family requested it. The ADM stated if a resident had a waiver in the future, it would be notated on the Kardex, which was what the CNAs referred to when referring to resident care needs. The ADM also stated the facility implemented a new process where residents who need to be fed, assisted or supervised while eating would be sat at a long table in the dining room and their meal tickets would be modified and highlighted so the nurse checking trays would know they needed to sit there. The ADM stated it was important to supervise residents during mealtimes in the dining room in order to look for any changes of condition and any signs/symptoms of choking or aspiration, as well as to check textures and liquid consistencies. She stated management was going to QAPI all their findings and do random audit checks in the dining room between herself and the DON/designees through the week. Those checks would include ensuring no residents were sharing food, correct diets/textures were being served and resident with feeding assistance/supervision needs were being placed at the designated table, as well as ensure staff members also know which resident need supervision and assistance when in the dining room. The ADM was informed the Immediate Jeopardy was removed on 04/02/25 at 1:03 PM. The Facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and at a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.