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	11/26/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident free from physical restraints not required to treat the residents' medical symptoms as was possible for one of three residents (Resident #3) reviewed for restraints. The facility failed to ensure Resident #3 had physician orders for the bolster mattresses on her bed. This failure could place residents at risk of not having an environment free from physical restraints.Findings included: Record review of Resident #3's Face Sheet, dated 10/07/25, reflected she was a [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included lack of coordination and seizures (uncontrolled movements). Record review of Resident #3's Quarterly MDS assessment, dated 9/01/25, reflected a BIMS score of 9 indicating moderate cognitive impairment. The resident had active diagnoses of muscle weakness and seizures. Record review of Resident #3's Comprehensive Care Plan, dated 10/05/25, reflected a plan of care for risk of falls and seizures. None of the care plans reflected an intervention for the use of a bolster mattress. For ADL care, it reflected the resident required total assistance Record review of Resident #3's physician orders, dated 10/07/25, reflected no physician order for the bolster mattress. In an observation on 10/07/25 at 8:26 AM, Resident #3 was observed with a bolster mattress on her bed. In an interview and observation on 10/07/25 at 8:30 AM, LVN I stated she was not sure if Resident #3 had physician orders for the bolster mattress but would check. LVN I checked and she stated the resident had the bolster mattress care planned but she did not have physician orders. In an interview on 10/07/25 at 8:45 AM, the Interim DON and LVN I stated they were not sure if Resident #3 needed physician orders for the bolster mattress on her bed. The DON stated hospice may have orders for the device. They stated they were not aware of any risk to the resident if she did not have the physician orders but would work on obtaining orders for the bolster mattress. The facility's policy, Physical Restraints Application, dated October 2010, reflected, The purpose of this procedure is to provide safety or postural support of a resident to prevent injury to the resident or others when the resident has medical symptoms that warrant the use of restraints.

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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Vista Ridge Nursing & Rehabilitation Center	700 E Vista Ridge Mall Dr Lewisville, TX 75067

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that residents, who needed respiratory care, were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for three of six residents (Resident #3, #8, and #10) reviewed for respiratory care. The facility failed to ensure Resident #3 and #8's nebulizer mask was properly stored in a bag when not in use on 10/07/25. The facility failed to ensure Resident #10's CPAP mask was properly stored in a bag when not in use on 10/07/25. These failures could place residents at risk for respiratory infection and not having his respiratory needs met.Findings included: 1. Record review of Resident #3's Face Sheet, dated 10/07/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included chronic cough and shortness of breath. Record review of Resident #3's Quarterly MDS assessment, dated 9/01/25, reflected her BIMS score of 9 indicating moderate cognitive impairment. The resident had active diagnoses of chronic cough and shortness of breath. Record review of Resident #3's Comprehensive Care Plan, dated 10/05/25, reflected a plan of care for oxygen therapy. Record Review of Resident #3's physician orders, dated 10/07/25, reflected Ipratropium -Albuterol Sulfate Inhalation Solution 0.5-2.5 (3) MG/3 ML 1 Vial orally every 6 hours as needed for SOB. In an observation on 10/07/25 at 8:26 AM, Resident #3 was observed with a nebulizer mask sitting on top of a nightstand unbagged. In an interview and observation on 10/07/25 at 8:30 AM, LVN I was shown by the Surveyor Resident #3's nebulizer mask unbagged. She stated the resident normally used the mask throughout the day and forgot to bag it. She stated it was the nursing staff's responsibility to ensure the mask was bagged to avoid an infection. 2. Record review of Resident #8's Face Sheet, dated 10/07/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnosis included COPD (shortness of breath). Record review of Resident #8's Quarterly MDS assessment, dated 7/13/25, reflected her BIMS score of 13 indicating intact cognition. The resident had active diagnoses of COPD (shortness of breath). Record review of Resident #8's Comprehensive Care Plan, dated 3/14/25, reflected a plan of care for oxygen therapy by way of a nebulizer. Record Review of Resident #8's physician orders, dated 10/07/25, reflected Ipratropium -Albuterol Sulfate Inhalation Solution 0.5-2.5 (3) MG/3 ML 1 Vial orally every 6 hours as needed for SOB. In an observation on 10/07/25 at 8:41 AM, Resident #8 was observed with a nebulizer mask sitting in the drawer of her nightstand, unbagged. 3. Record review of Resident #10's Face Sheet, dated 10/07/25, reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnosis included sleep apnea (sleep disorder). Record review of Resident #10's Quarterly MDS assessment, dated 9/11/25, reflected her BIMS score of 12 indicating moderate cognitive impairment. The resident had an active diagnosis of sleep apnea. Record review of Resident #10's Comprehensive Care Plan, dated 3/14/25, reflected a plan of care for sleep apnea with the use of a CPAP machine. Record Review of Resident #10's physician orders, dated 10/07/25, reflected CPAP to be applied at bedtime on setting 14. In an observation on 10/07/25 at 8:41 AM, Resident #10 was observed with a CPAP mask sitting on top of her nightstand, unbagged. In an interview and observation on 10/07/25 at 8:48 AM, LVN B was shown by the Surveyor the nebulizer mask for Resident #8 and the CPAP mask for resident #10 unbagged. She stated the residents used the masks throughout the day and she had to remind them to place them into a bag when they were done. She stated it was overall the nurse's responsibility to ensure the masks were bagged to avoid infections. In an interview on 10/07/25 at 12:33 PM, the interim DON was told by the Surveyor about Resident #3, #8, and #10 not having their mask bagged when not in use. She stated she expected the resident's mask to be air dried and then bagged after breathing treatments. When asked the risk of not bagging the mask, the DON just stared at me and initially did not say anything. She then repeated her expectations and stated sometimes the residents removed the mask from the bag. Review of the facility's policy Oxygen Use (Respiratory Therapy) Prevention of Infection, dated November 2011, reflected, The purpose of this procedure is to guide prevention of infection associated with the respiratory tasks and equipment, including ventilators, among residents and staff.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the nurse call system was accessible for residents to call for staff assistance through a communication system which relays the call directly to a staff member of a centralized staff work area for seven of ten residents (Residents #1, #2, #4, #5, #6, #7, and #9) reviewed for Reasonable Accommodation of Needs. The facility failed to ensure the call light system in Residents #1, #2, #4, #5, #6, #7, and #9's rooms were in a position accessible to the residents on 10/07/25 on the 200, 300, and 400 halls. This failure could place residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings included: 1. Record review of Resident #1's Face Sheet, dated 10/07/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included muscle weakness and need for assistance with personal care. Record review of Resident #1's Quarterly MDS assessment, dated 8/22/25, reflected a BIMS score of 11 indicating moderate cognitive impairment. For ADL care, this MDS reflected Resident#1 required extensive assistance, and an active diagnosis of need for assistance with personal care. Record review of Resident #1's Comprehensive Care Plan, dated 8/17/25, reflected no plan of care for the resident having the call light within reach. In an observation on 10/07/25 at 8:22 AM, Resident #1's call light was hanging over a chair next to the bed, out of reach of the resident. 2. Record review of Resident #2's Face Sheet, dated 10/07/25, reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included lack of coordination and a history of falls. Record review of Resident #2's Quarterly MDS assessment, dated 09/10/25, reflected a BIMS score of 11 indicating moderate cognitive impairment. For ADL care, this MDS reflected the Resident #2 required total assistance. Resident #2's active diagnoses included lack of coordination and difficulty walking. Record review of Resident #2's Comprehensive Care Plan, dated 8/05/25, reflected the resident was a fall risk and an intervention included ensuring the call light was within reach of the resident and to encourage the resident to use it. In an observation on 10/07/25 at 8:22 AM, Resident #2's call light was hanging from the lower left side of the bed frame out of reach of the resident. 3. Record review of Resident #4's Face Sheet, dated 10/07/25, reflected she was an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included lack of coordination and a history of falls. Record review of Resident #4's Quarterly MDS assessment, dated 09/04/25, reflected a BIMS score of 12 indicating moderate cognitive impairment. For ADL care, it reflected the resident required substantial assistance. Resident #4's active diagnoses included lack of coordination and muscle weakness. Record review of Resident #4's Comprehensive Care Plan, dated 4/01/25, reflected the resident was a fall risk and an intervention included ensuring the call light was within reach of the resident and to encourage the resident to use it. In an observation on 10/07/25 at 8:32 AM, Resident #4 was lying in bed and the call light was on the floor, near the foot of the bed, out of reach of the resident. 4. Record review of Resident #5's Face Sheet, dated 10/07/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included lack of coordination and repeated falls. Record review of Resident #5's Quarterly MDS assessment, dated 7/15/25, reflected a BIMS score of 11 indicating moderate cognitive impairment. For ADL care, it reflected the resident required limited assistance. Resident #5's active diagnoses included lack of coordination and repeated falls. Record review of Resident #5's Comprehensive Care Plan, dated 7/11/25, reflected the resident was a fall risk and an intervention included ensuring the call light was within reach of the resident and to encourage the resident to use it. In an observation on 10/07/25 at 8:33 AM, Resident #5 was lying in bed and the call light was on top of a wheelchair, and out of reach of the resident. 5. Record review of Resident #6's Face Sheet, dated 10/07/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included lack of coordination and a history of falls. Record review of Resident #6's Quarterly MDS assessment, dated 9/05/25, reflected a BIMS score of 13 indicating intact cognitive response. For ADL care, it reflected the resident required substantial assistance. Active diagnoses included lack of coordination and muscle weakness. Record review of Resident #6's Comprehensive Care Plan, dated 9/17/25, reflected the resident was a fall risk and an intervention included ensuring the call light was within reach of the resident and to encourage the resident to use it. In an observation on 10/07/25 at 8:33 AM, Resident #6 was in bed and the call light was on the floor, near a waste basket, out of the resident's reach. 6. Record review of Resident #7's Face Sheet, dated 10/07/25, reflected he was an [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included lack of coordination and a