

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Villages of Lake Highlands		STREET ADDRESS, CITY, STATE, ZIP CODE 8615 Lullwater Dr Dallas, TX 75238	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637</p> <p>Based on observation, interview and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one of four residents (Resident #1) reviewed for accidents and supervision.</p> <p>1. The facility failed to ensure Resident #1 was transferred from her bed to her wheelchair utilizing a Hoyer lift (mechanical lift) with two staff members present as indicated on her care plan.</p> <p>2. The facility failed to ensure CNA A transferred Resident #1 using a hoyer lift, bruising Resident #1's right arm and left wrist and a skin tear to her left knee.</p> <p>The noncompliance was identified as PNC. The noncompliance began on 07/02/24 and ended on 07/02/24. The facility had corrected the noncompliance before the survey began.</p> <p>These failures could place residents at risk for neglect, harm, pain, and injuries .</p> <p>Findings include:</p> <p>Record review of Resident #1's Admission record, dated 10/24/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE].</p> <p>Record review of Resident #1's Quarterly MDS Assessment, dated 9/25/24, reflected she had moderately impaired cognition. Her diagnoses included congestive heart failure (chronic condition in which the heart does not pump blood as it should); anemia (lack of blood cells needed to carry adequate oxygen to the body); Hypertension (high blood pressure); depression; muscle wasting and atrophy (loss of muscle tissue and strength); back and joint pain. She required the use of a wheelchair and maximum assistance for bed mobility, transfers, dressing and bathing.</p> <p>Record review of Resident #1's Care Plan reflected the following entries:</p> <p>Problem: The resident has limited physical mobility r/t Weakness, Muscle Wasting and Atrophy Date initiated 11/10/22. Interventions . Transfers: The resident is totally dependent on 2 staff for locomotion using Hoyer Lift.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Villages of Lake Highlands		STREET ADDRESS, CITY, STATE, ZIP CODE 8615 Lullwater Dr Dallas, TX 75238	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Order Summary Report, dated 10/24/24, reflected the following entries:</p> <p>May Use Mechanical Lift. Order date 11/9/22.</p> <p>May Use Mechanical Lift with 2 Person Assist. Order date 3/23/23.</p> <p>Monitor: Left knee with steri strips for s/s of infection, warmth, or drainage. Notify MD, if there are increased changes/worsening every shift for skin tear monitoring. Order date 7/2/24.</p> <p>Record review of Resident #1's Progress Notes reflected the following entries:</p> <p>Entry dated 7/2/24 at 11:30 AM: reflected Th8is [sic] nurse along with DON notified by [LVN B] that resident has new bruising to her BUE, BLE, and skin tear to Left knee. Skin assessment completed at this time by DON/CNO at this time with above findings noted. Resident reported CNA transferred her without a Hoyer lift during morning care. CNA removed from the floor immediately, POA, Administrator, MD, HHSC, and DPS all notified. The entry was signed by the CNO.</p> <p>Entry dated 7/2/24 at 2:33 PM titled, Skin Only Evaluation: Skin Issue: Bruising. Skin Issue Location: MULTIPLE BRUISING ON LEFT OUTTA [sic] KNEE</p> <p>Skin Issue: Bruising. Skin Issue Location: MULTIPLE BRUISING ON RIGHT ARM</p> <p>Skin Issue: Bruising. Skin Issue Location: LEFT WRIST</p> <p>Skin Issue: Skin Tear. Skin Issue Location: LEFT KNEE</p> <p>Clinical Suggestions: Evaluated for pain, discomfort. PRN medication administered, and effectiveness evaluated. Area evaluated for signs of infection: redness, warmth, swelling, increased temperature, drainage, etc. Area evaluated for signs of healing: approximation, pink tissue, scabbing, etc. The entry was signed by LVN B.</p> <p>During an observation and interview on 10/24/24 at 9:38 AM, Resident #1 was observed lying in her bed. A sign above her bed reflected Hoyer Lift. Resident #1 stated she just finished breakfast and staff would be there soon to get her up. When asked about the incident with CNA A, Resident #1 stated it only happened once and never since. She stated, they took care of it, I don't want to talk about it. She denied any concerns about her care. A nickel-sized bruise was observed on her L hand between her thumb and first finger. When asked about the bruise, Resident #1 stated, I'm 101, my skin is so frail, just touch me and I bruise, I bruise very easily. She denied any staff being rough with her since that last one. CNA C and CNA D entered the room, provided incontinent care and changed Resident #1's clothing. A small scab was observed on her left knee. No other bruises or skin tears were observed. LVN A entered the room with a Hoyer lift. All three staff assisted Resident #1 to her wheelchair utilizing the Hoyer lift. Resident #1 tolerated the transfer well. Resident #1 could not recall how she sustained the injury to her left knee. She declined any further interview.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Villages of Lake Highlands		STREET ADDRESS, CITY, STATE, ZIP CODE 8615 Lullwater Dr Dallas, TX 75238	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/24/24 at 1:59 PM, LVN B stated she was working the day of the incident involving Resident #1. She stated Resident #1 had always been transferred using a mechanical lift. LVN B stated, on 7/2/24, she was making her normal rounds when she checked on Resident #1 and noticed the bruising on her arm and skin tear on her knee. She described the injuries as looking fresh. She stated Resident #1 pointed at her arms and said, look what that aide did to me. LVN B stated Resident #1 had bruises on both arms, her left forearm near her wrist and her right forearm. She stated she had a fresh skin tear on her left knee. She stated Resident #1 told her the CNA transferred her to her chair without using the lift. LVN B stated she assessed Resident #1's skin, and she and another nurse cleaned and dressed her skin tear. She stated she reported the incident to the Administrator, DON and CNO right away. She stated she also called Resident #1's physician and responsible party. LVN D stated CNA A was not present when she assessed Resident #1, but she knew it was her because CNA A was working her hall that morning. LVN B stated she was sitting at the nurse's station while CNA A was rounding and never asked her for any assistance or reported any issues with Resident #1's skin. She stated she had only worked with CNA A a couple of times prior to the incident. She stated she never heard of anything like that happening before because everybody knows [Resident #1] is a 2 person assist. She stated the sign above her bed indicated Hoyer Lift was definitely there the day the incident occurred. She stated CNA A was the only aide working that unit that day. LVN B stated the CNAs typically assisted each other with transfers or requested the charge nurse to assist. She stated there had been no further issues with Resident #1 since the incident. LVB B stated she received in-service training related to safe transfers again after the incident which included ensuring proper transfer technique was used and there should always be 2 staff present for mechanical lift transfers. She stated the risk of improperly transferring a resident was injury.</p> <p>During an interview with the CNO and the DON on 10/24/24 at 2:53 PM, the CNO stated CNA A admitted to them she transferred Resident #1 alone that day. She stated CNA A told her there was no one around to help. The CNO stated LVN B told her, I was sitting right there, why didn't you call me? She stated CNA A stopped answering their questions and was sent home. The DON stated she was informed by LVN B of the incident and interviewed Resident #1 who told her the CNA had been rough with her during care. She stated she immediately reported it to the Administrator and CNO. The DON stated both she and the CNO observed Resident #1's wounds and her skin tear looked fresh. She stated they pulled CNA A immediately from the floor. She stated LVN B notified the physician and received treatment orders and obtained an order for a psychological consult. She stated the Administrative staff initiated safe surveys for all residents and skin assessments. The CNO stated they terminated CNA A's employment and initiated in-service training related to transfers for all nursing staff as well as initiating a checklist used to conduct weekly Hoyer spot checks. She stated the spot checks included observing staff during transfers to ensure they were done correctly. The DON stated the Hoyer Lift signage in the room was there prior to the incident and she believed there was sufficient staff to ensure resident safety.</p> <p>During an interview with the Administrator on 10/24/24 at 3:00 PM, he stated he knew Resident #1 very well and went to see her right after hearing about the incident. She was upset but doing okay. He stated, when he spoke to CNA A about the incident, she acted like she didn't do anything wrong and tried to say there was no one available to assist her. If no one was available, you wait a few minutes until someone was. The Administrator stated the risk of not using the lift was injuries. He stated LVN B told them she was sitting nearby and he saw the Hoyer lift in the hallway near Resident #1's room when he went to see her.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Villages of Lake Highlands		STREET ADDRESS, CITY, STATE, ZIP CODE 8615 Lullwater Dr Dallas, TX 75238	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 10/24/24 at 3:28 PM, CNA A stated she did not know what happened to Resident #1, and the resident had very fragile skin and her bruises and skin tear were already there before she provided her care. She stated she knew she was supposed to report any skin issues to the charge nurse but did not that day because the nurse was not at the desk, so she moved on. She stated she had a different assignment than usual that day and was not aware Resident #1 required a mechanical lift for transfers and denied seeing the sign posted above her bed. CNA A stated she felt like the facility staff was looking for somebody to blame for her bruises and had approached her because they saw the skin tear. CNA A stated she transferred Resident #1 to her chair on 7/2/24 by herself by placing her arms under Resident #1's arms and moving her to her chair. She stated Resident #1 was unable to stand but could bear some weight. CNA A stated Resident #1 did not complain or say anything to her about the transfer. She stated she received previous training on safe transfers at the facility and had worked there since March 2024. She stated she had been a CNA since 2005. She stated she did not know Resident #1 well and did not ask the Charge Nurse or the resident how she was to be transferred. She stated she could have asked the Charge Nurse or checked the computer to determine how Resident #1 was to be transferred out of bed, but she did not. She stated, From looking at her, I felt she wasn't too heavy. She stated she did not use a gait belt and transferred her using her arms under the resident's arms. CNA A stated she knew if a mechanical lift was used, there should always be 2 people present. She stated she did not know what the risk was for Resident #1 or even that she needed a mechanical lift.</p> <p>In an interview on 10/24/24 at 5:44 PM, the DON stated all nursing staff completed in-service trainings related to Abuse and Neglect as well as safe transfers. The DON stated CNA A had received her initial skills check off training upon hire, which included transfers of all types.</p> <p>Interviews with the facility nursing staff which included 5 CNAs, 3 LVNs, and 2 RNs, covering all three shifts and weekends, were conducted on 10/24/24 between 9:51 AM and 4:50 PM. The staff revealed they received the in-service training and were able to describe how to determine the type of transfer needed for each resident by checking with nursing staff, rehabilitation staff, and/or the resident's care plan. Staff reported 2 staff must be present at all times for residents requiring mechanical lifts or maximum assistance as there was a risk for injuries.</p> <p>Record review of CNA A's personnel file reflected she completed a Certified nursing Assistant Orientation Skills Checklist on 3/11/24. The checklist included transferring residents from bed to chair and back ambulatory and non-ambulatory; and using a mechanical lift. Her personnel file included a letter, dated 7/2/24 and signed by the DON and HR Coordinator. The letter reflected, .Upon interview of concern [CNA A] stated she assisted resident with care and verbalized she was unaware of anything that was done wrong. admitted to transferring resident via self alone without assistance which is a violation of company policy. [CNA A] failed to carry out the proper transfer policy which she was previously educated on. Employee terminated breach of facility policy.</p> <p>Record review of the facility's Provider Investigation Report, dated 7/8/24, reflected the facility self-reported and investigated the matter to HHSC in a timely manner. The report reflected the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Villages of Lake Highlands		STREET ADDRESS, CITY, STATE, ZIP CODE 8615 Lullwater Dr Dallas, TX 75238	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Investigation Summary section reflected, Resident #1 reported to her nurse that an aide was rough during provided care. The DON/Abuse coordinator were immediately notified. Resident #1 stated CNA A transferred her to a chair without the use of a Hoyer lift. When asked by staff how her bruising and skin tear had occurred, Resident #1 stated the aide grasped her arms and put her in her chair, but she did not know how the skin tear had occurred.</p> <p>The report reflected CNA A was immediately removed from the floor and suspended. An emergency QAPI was conducted, Abuse, Neglect, and Transfer in-service trainings were initiated. Resident interviews were conducted on all interviewable residents and assessments were conducted on all non-interviewable residents. Facility wide skin assessments were completed. The investigation concluded it was an isolated incident.</p> <p>Record review of an included statement signed by the Administrator reflected the following:</p> <p>2 July 2024 Met with [Resident #1] this am after transfer by aid and upon report from nursing team. [Resident #1] was upset by the transfer and told me the aid [CNA A] identified as the aid on the hall by staff just came in and picked her up and put her in the chair. I asked her how her knee was hurt and she didn't know how that happened but said she held her by the arms and said 'she was so strong and just put me in the chair.' I asked [Resident #1] if this had ever happened before and she said 'no, I don't know why she didn't use the machine Like they always do' She commented she knew that was wrong and tried to hit the aid. I asked her if the aid hit her and she said 'no, but seemed so mean and she always talks so nicely to me, then she went and got me a sprite.' I reassured [Resident #1] she was safe; I was handling all of this with our team and the aid would never be back to care for her or anyone else and we were investigating why this happened. I know [Resident #1] well and sat with her to explain how this can be very upsetting and if she was ok with it, I would like to have a professional come speak with her for extra support and she agreed. I told her we needed to call her family and she agreed to that.</p> <p>I met with the aid [CNA A] who was removed from the floor in the DON office with nursing leadership. I asked her, according to her training, why she didn't use the Lift with a helper for a routine transfer to get her up like we do every morning and she said she couldn't find anyone, they were with other residents. I did confirm the lift was outside the door of [Resident #1's] room the aid had brought down and the nurse, was sitting a few feet away at the station. I further asked why she would do that when she knew better has been an aid here since March and she shrugged her shoulders and said 'those bruises on her arm look old to me. 1 followed up with [Resident #1] to check on her later that afternoon. She of course remembers the event and told me she was doing better and felt safe with the nurses but still doesn't understand why this happened.</p> <p>3 July 2024 Met with [Resident #1] this morning and afternoon to check-in on her. She said a Lady from the Army came to see her (Police officer we called yesterday came by to interview her) No issues reported and she feels safe.</p> <p>4 July 2024 Checked in with [Resident #1] this morning after breakfast to check on how she was doing. No new issues or concerns. She asked me what happened to the aid and told she has been terminated and hasn't been back in the building since her report. Complete investigation and QAPI information conducted by team attached.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Villages of Lake Highlands		STREET ADDRESS, CITY, STATE, ZIP CODE 8615 Lullwater Dr Dallas, TX 75238	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of an in-service, dated 7/2/24, reflected all staff received training on Resident Abuse, Neglect, and Resident Rights.</p> <p>Record review of an in-service, dated 7/2/24, reflected all nursing staff received training related to transfers, Hoyer lifts and gait belts. The Inservice training report reflected:</p> <p>All Hoyer transfers must be with 2 staff members. No Exceptions. If you are unsure of how a resident transfers, ask the nurse. If a resident cane bare [sic] weight, transfer is with a gait belt and additional staff if needed. If resident is no longer able to transfer safely, inform management and therapy.</p> <p>Record review of the facility's policy titled, Lifting Machine, Using a Mechanical, dated revised July 2017, reflected the following: Purpose: The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instructions. General Guidelines: 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift .Steps in Procedure: 1. Before using a lifting device, assess the resident's current condition, including: a. Physical: (1) Can the resident assist with transfer? (2) Is the resident's weight and medical condition appropriate for the use of a lift? b. Cognitive/Emotional: (1) Can the resident understand and follow instructions? (2) Does the resident express fear or appear anxious about the use of a lift? (3) Is the resident agitated, resistant, or combative</p>