

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 09/13/2025
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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice for 1 (Resident #1) of 20 residents reviewed for quality of care. The facility failed to provide Resident #1 with diabetic treatments on 09/10/25 which included checking blood sugars and administering insulin. The non-compliance was identified as past non-compliance (PNC). The IJ began on 09/10/25 and ended on 09/12/25 and the facility had corrected the non-compliance before the state's investigation began. This failure could place residents' health and safety at risk. Findings included: Record review of Resident #1's face sheet, dated 09/12/25 reflected, she was a [AGE] year-old female who was admitted [DATE] and diagnosed with but not limited to: Type 2 Diabetes Mellitus (chronic disease characterized by high blood sugar) with diabetic chronic kidney disease (Diabetic nephropathy affects the kidneys' usual work of removing waste products and extra fluid from the body), end stage renal disease (chronic kidney disease progresses to a point where the kidneys lose nearly all their filtering ability, atherosclerotic heart disease of native coronary artery without angina pectoris (A condition where the arteries supplying blood to the heart become narrowed due to the accumulation of plaque and altered mental status unspecified. Record review of Resident #1's MDS assessment, dated 09/10/25 reflected his BIMS score was 06 which indicated severe cognitive impairment. Record review of Resident #1's orders, dated 09/10/25 reflected: Humalog Kwik Pen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 70 - 240 = 0 UNITS <70 INSTITUTE HYPOLYCEMIA PROTOCOL AND CALL MD; 241 - 300 = 2 UNITS; 301 - 350 = 3 UNITS; 351 - 400 = 4 UNITS >400 GIVE 5 UNITS AND CALL MD, subcutaneously at bedtime for DM start date on 09/05/25 at 6:00pm. Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 23 unit subcutaneously one time a day for DM start date of 09/10/25 at 8am INSULIN LISPRO 100 UNIT/ML VL Inject as per sliding scale: if 70 - 130 = 0 UNIT <70 INSTITUTE HYPOGLYCEMIA PROTOCOL AND CALL MD; 131 - 180 = 1 UNIT; 181 - 240 = 2 UNITS; 241 - 300 = 3 UNITS; 301 - 350 = 4 UNITS; 351 - 400 = 5 UNITS >400 GIVE 6 UNITS AND CALL MD, subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITH DIABETIC CHRONIC KIDNEY DISEASE (E11.22) start date of 09/08/25 at 7:30 am Record review of Resident #1's TAR for the month of September 2025 reflected on 09/10/25: At 7:30am Resident #1 blood sugar was 522 and injected 9 units of Insulin Lispro 100unit/ML signed by LVN B [SH1] [SH1] At 8:00 am Resident #1's blood sugar was 522 and injected 23 units of Insulin Glargine 100 unit/ml, signed by LVN A At 11:30 am Resident #1 blood sugar was 522 and injected 9 units of Insulin Lispro 100unit/ML, signed by LVN A At 4:30 pm Resident #1 blood sugar was 522 and injected 4 units of Insulin Lispro 100unit/ML, signed by LVN A At 8:00 pm Resident #1 blood sugar was 522 and injected 1 units of Insulin Lispro 100unit/ML, signed by LVN A At 6:00 pm Resident #1 sugar was 522 and injected with 4 units of Humalog kwik pen, signed by LVN A Record review of Resident #1 progress note dated 09/10/25 at 6:59 am reflected: .After 6AM, resident requested BS check and it was 522mg/dl, [MD] notified and said to give sliding scale, order carried out and 6 units of insulin lispro given by LVN B Record review of Resident #1 progress note dated 09/10/25 at 1:39 pm reflected: Resident #1 vital signs were noted to be B/p 158/74, pulse 93, temp 98.0, resp 17 and o2 sat 97% . at 7:30 AM. [Resident #1] was noted to be laying in bed with no concerns noted at that time. Prior to medication administration. Prior to administration of routine Lantus order resident request an addition 6 units of insulin. [LVN A] educated resident that [LVN A] could not administer an addition dose of insulin as that would be double dosing and there isn't an order. [LVN A] administered resident's routine Lantus order at 825 AM. [LVN B] instructed the [resident #1] that [LVN A] would recheck her blood sugar but her husband transported resident from facility. Resident #1 [family member #1] arrived at facility with wheelchair stated, I'm taking [Resident #1] for an evaluation as she was in DKA and we will return later. [Family member #1] also stated, [Resident #1] knows her body. When asked how did [family member #1] determine she was in DKA. [Resident #1] was seated in wheelchair and smiled at [LVN A] when exiting facility with no distress noted. [LVN A] then received a phone call from [Resident #1 family member #2] aggressively state that [Resident #1] blood sugar was taken at 5:30am and that no one has done anything or even check on [Resident #1]. [LVN A] attempt to tell [family member #2] what was done while she continue to call [LVN A] a liar, a neglectful nurse until she hung up. by LVN A Record review of Resident #1 progress notes dated 09/10/25 at 4:54 pm [LVN M 1 and [Admin] spoke with [Resident #1 family member #1] regarding the status of [Resident #1] and to follow up</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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Findings included: Record review of Resident #1's face sheet, dated 09/12/25 reflected, she was a [AGE] year-old female who was admitted [DATE] and diagnosed with but not limited to: Type 2 Diabetes Mellitus (chronic disease characterized by high blood sugar) with diabetic chronic kidney disease (Diabetic nephropathy affects the kidneys' usual work of removing waste products and extra fluid from the body), end stage renal disease (chronic kidney disease progresses to a point where the kidneys lose nearly all their filtering ability. atherosclerotic heart disease of native coronary artery without angina pectoris (A condition where the arteries supplying blood to the heart become narrowed due to the accumulation of plaque and altered mental status unspecified. Record review of Resident #1's MDS assessment, dated 09/10/25 reflected his BIMS score was 06 which indicated severe cognitive impairment. 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Record review reflected Resident#1 was diagnosed with DKA (serious complication of diabetes that occurs when the body lacks sufficient insulin This condition leads to high blood sugar levels and the accumulation of acidic substances called ketones in the body.) Record review revealed Resident#1 insulin level was 364 at 1:55 pm. Record review revealed Resident#1 received intravenous fluids and insulin). During an interview on 09/13/25 at 2:30 pm, the Medical Director stated he was called about Resident #1's blood sugar reading being in the 500's on 09/10/25 about 6:45 am. The Medical Director stated he sent new orders and additional monitoring steps for Resident#1. The Medical Director stated staff had to check Resident#1 blood sugars before giving insulin to make sure the right number of units are given. The Medical Director stated staff cannot falsify documentation because that will put residents in the facility health at risk. The non-compliance was identified as past non-compliance (PNC). The PNC began on 09/10/25 and ended on 09/12/25. The facility had corrected the non-compliance before the state's investigation began. During an interview on 09/12/25 at 3:30 pm, The CN/DON stated staff have had competency testing blood sugars, given insulin, abuse/neglect and documentation. The CN/DON stated LVN A was suspended after Resident#1 family stated he did not do her blood sugar check on 09/10/25. The CN/DON stated after investigating the incident, LVN A stated he did not check Resident#1 blood sugar and used LVN B readings the morning of 09/10/25. The CN/DON and Admin reported LVN A license to the BON on 09/11/25. The Admin and DON terminated</p>		