

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 04/18/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43843</p> <p>Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for two (Residents #71 and #62) of 12 residents reviewed for dignity.</p> <p>The facility failed to ensure Residents #71 and #62 had the right to a dignified existence when staff stood over the resident while feeding the resident.</p> <p>This failure could affect the residents by placing them at risk for a loss of dignity, decreased self-worth and decreased self-esteem.</p> <p>Findings included:</p> <p>Review of the face sheet for Resident #62 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Primary diagnosis of Alzheimer's disease with early onset and secondary diagnosis and Type 1 diabetes mellitus with hyperglycemia (high blood glucose).</p> <p>Review of Resident #62's MDS quarterly assessment, dated 01/09/2024, revealed Resident #62 had a BIMS score of 00 (severe cognitive impairment). Functional abilities and goals revealed eating- Substantial/maximal assistance - Helper does more than half the effort.</p> <p>Review of Resident #62's care plan dated 07/23/2020, reflected: Resident will consume 75% of ordered diet each day. Interventions: Provide cues, reminders to stay on task for meals. Supervision, set up as needed.</p> <p>Review of the face sheet for Resident #71 revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with a primary diagnosis dementia and secondary diagnosis of hypothyroidism (the thyroid gland can't make enough thyroid hormone to keep the body running normally).</p> <p>Review of Resident #71's MDS comprehensive assessment, dated 02/08/2024, revealed a BIMS score of 3 (severe cognitive impairment). Functional abilities and goals revealed eating- setup and clean up assistance.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #71's care plan dated 03/12/2024, revealed resident will consume 75% of ordered diet each day. Interventions Ensure Resident was in proper position, with dentures for meals.</p> <p>Observation on 04/18/2024 at 12:28 PM revealed CNA L stood next to Resident #71 and Med Tech M stood next to resident #62 in the dining room and assisted the residents with lunch.</p> <p>Interview on 04/18/2024 at 12:51 PM with CNA L revealed she returned from lunch and just started feeding the resident. She stated she was trained to sit down next to the resident, so the resident did not feel rushed.</p> <p>Interview on 04/18/2024 at 12:54 PM with Med Tech M she was trained to sit next to the resident during meal assistance. She stated she did not sit next to the resident because she had back pain, and it was uncomfortable for her to sit next to the resident.</p> <p>Interview on 04/18/2024 at 12:41 PM with LVN N revealed staff were trained to sit next to residents when they assisted them with feeding. She stated direct staff were supposed to sit and not stand while assisting the residents with feeding, so residents felt comfortable and did not feel not rushed.</p> <p>Review of the facility's policy titled Assistance with Meals, dated March 2022, reflected: Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: Not standing over residents while assisting them with meals.</p>

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637</p> <p>Based on observations, interviews, and record review the facility failed to ensure residents were free of any significant medication errors for 1 (Resident #389) of 8 residents reviewed for pharmacy services.</p> <p>The facility failed to prevent LVN A from injecting an unknown amount of Kenalog (a steroid for pain relief) and lidocaine (numbing medicine) medication into Resident #389's arm despite an order to hold the medications on the medication cart for the physician to administer into the resident's knees.</p> <p>The non-compliance was identified as past non-compliance. The Immediate Jeopardy (IJ) began 02/01/24 and ended on 02/02/24. The facility corrected the non-compliance before the survey began.</p> <p>This failure placed residents at risk for harm and/or serious injury.</p> <p>Findings included:</p> <p>Record review of Resident #389's Admission Record revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including influenza due to identified influenza A virus with pneumonia, acute respiratory failure with hypoxia (low levels of oxygen in the tissues), Type 2 diabetes, pain in the right knee, pain in the left knee, and difficulty walking.</p> <p>Record review of Resident #389's Admission MDS assessment dated [DATE] revealed she had a BIMS score of 14 indicating she was cognitively intact. Her preferred language was Spanish. She had functional limitations to her range of motion in both lower extremities (legs).</p> <p>Record review of Resident #389's Order Summary Report dated 04/17/24 revealed the following orders:</p> <p>Kenalog [steroid used to treat inflammatory conditions] injection suspension 40 mg/ml .2 milliliter intra-articularly [into a joint space] one time only for BL [bilateral] knee pain for 14 days hold in cart for [MD B]. Order dated 01/31/24.</p> <p>Xylocaine Injection Solution 1% (Lidocaine HCL (local Anesth.)) [numbing medication] 10 milliliter intra-articularly one time only for BL knee pain for 14 Days hold in cart for [MD B]. Order dated 01/31/24.</p> <p>Monitor: left shoulder for s/s of infection, warmth, or drainage. Notify MD of any changes. Every shift for prophylactic. Order dated 02/01/24.</p> <p>Record review of Resident #389's Medication Administration Record dated 02/01/24 through 02/29/24 revealed the following entries:</p> <p>Kenalog [steroid used to treat inflammatory conditions] injection suspension 40 mg/ml .2 milliliter intra-articularly [into a joint space] one time only for BL [bilateral] knee pain for 14 days hold in cart for [MD B] The order was signed as administered on 2/1/24 at 9:50 AM by LVN B.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Xylocaine Injection Solution 1% (Lidocaine HCL (local Anesth.)) [numbing medication] 10 milliliter intra-articularly one time only for BL knee pain for 14 Days hold in cart for [MD B]. The order was signed as administered on 2/1/24 at 9:50 AM by LVN A.</p> <p>Record review of Resident #389's Treatment Administration Record dated 02/01/24 through 02/29/24 revealed the following entry:</p> <p>Monitor: Monitor: left shoulder for s/s of infection, warmth, or drainage. Notify MD of any changes. Every shift for prophylactic Start date 02/02/24. The order was signed as completed every shift from 02/02/24 through 02/08/24.</p> <p>Record review of the facility's Provider Investigation Report dated 02/07/24 reflected the following:</p> <p>Description of the Allegation: 2/1/24 at [3:30 PM] [LVN A] reported administration of Kenalog/lidocaine injection to [Resident #389]. [LVN A] administered injection in right knee and left shoulder. Order placed by [MD B] to be administered by [MD B] with direction to hold in cart for [MD B]. [MD B] notified.</p> <p>Description of Assessment: Assessment to include skin/residual effects/ mobility completed upon notification of injection and revealed no adverse effects to resident. [MD B/MD C] notified. 2/2/24 Follow up assessment conducted at approximately 10am pain/skin/range of motion assessed, resident stated range of motion improved. [MD B] assessed resident in facility.</p> <p>Provider Response: Immediately upon notification nurse sent home on suspension pending investigation. MD notified, new order received to monitor for signs and symptoms of infection, resident assessed and interviewed with Spanish speaking translator, resident son notified. Nurse [LVN A] interviewed and resulted in termination of employment on 2/2/24 as well as reported to the Texas Board of Nursing due to practicing outside scope of practice.</p> <p>Investigation Summary: 2/1/2024 at [3:30 PM] [LVN A] reported administration of Kenalog/lidocaine injection to [Resident #389], [LVN A], administered injection in right knee and left shoulder. Order placed by [MD B] to be administered by [MD B] with direction hold in cart for [MD B]. Assessment to include skin/residual effects/mobility completed upon notification of injection and revealed no adverse effects to resident. 2/2/24 Follow up assessment conducted at approximately 10 am pain/signs symptoms of infection/skin/range of motion assessed, resident stated range of motion improved no adverse event noyed [sic] at this time. [MD B] assessed resident in facility.</p> <p>Provider Action Taken Post-Investigation: Out of an abundance of caution incident reported to HHCS [sic] and board of nursing for nurse practicing outside the scope of practice. Medication Administration, following physician orders/direction, and reporting in service/training conducted with all nursing staff. Additional direction/instruction to be placed on future Kenalog medication orders via MD.</p> <p>The following written statements were included with the Provider Investigation Report and reflected:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Statement dated 02/05/24 and signed by the ADON: On [DATE]st 2024 Pain injection that was to be administered by pain MD was administered by floor nurse, Medication was administered in her left shoulder according to the patient but it was meant for her bilateral knee. Res made aware of the error by nurse and will be monitored closely. Res stated that her shoulder feels a lot better since she was also experiencing shoulder pain. Son made aware and he is ok. Res is continued to be monitored, head to toe assessment done and some bruising is noted to her left deltoid area [muscle on the upper, outer arm at the shoulder]. [Admissions staff] present for Spanish translation, no s/s of distress noted, wctm [will continue to monitor].</p> <p>Statement dated 02/01/24 and signed by Admissions Staff: On 2/1/2024 I was called for translation services to assist [ADON]. I was told to translate to patient, [Resident #389], that she was given a pain shot administered by the nurse instead of [MD B] on the knees. While I was talking to [Resident #389], she stated that she received the shot on her shoulder, and feels relief, but was confused about the site of the shot as she was expecting to get it on her knees instead. The patient continued to show the site where the shot was given on her left shoulder and explained to me that she did see the nurse had more than one shot on her hands to give her, but she only gave her one, on her shoulder but nothing on her knees. She again stated that she felt the sharp pain come in her shoulder before she started to feel the relief and still feels the sore area of the shot. The patient told me she was feeling concerned that the nurse's statement would keep her from receiving the correct order of her pain medication on her knees. I informed [ADON] and he asked me to inform her that [MD B] and [MD C] will be in to see her on Friday [2/2/24] and they would discuss her medication and will see if they would be able to give her the shots on her knees.</p> <p>Statement dated 02/02/24 and signed by the DON and CNO. Nurse Interview: [LVN A] Incident-[Resident #389]. Order populated to [DATE]am; proceeded to mix solution for administration. The nurse admitted to being unaware how to mix solution and proceeded to google for instruction. Questioned if any supervisor was notified or attempt made to notify for assistance stated no. The nurse questioned if the order was completely read and replied with, she did not completely read the order. Informed of written instructions to hold for MD stated she was unaware, further stated no report seen and administered just as other medication retacrit [a medication given for anemia and injected subcutaneously beneath the skin]. Asked nurse if order instruction was seen as order stated to 'hold in cart for [MD B]' verbalized she did not see it. Inquired of administration nurse initially stated the injection was given in right knee. Inquired nurse to physically identify injection site exact location not admitted. Nurse next verbalized she would be 'completely honest' she divided injection into two 5 ml syringes with small approximately 22' gauge [needle] and physical identified location injection site via pointing to anterior/lateral [outer and toward the front] right knee and L deltoid, two cleaned with alcohol, no bleeding pain noted at injection site. 3:30p-3:45p Nurse reported to [ADON] she gave an injection she did not think she was able to give. [MD C/MD B] immediately notified via [ADON/CNO]. Skin assessment performed.</p> <p>Record review of Resident #389's SNF Rounding Note dated 01/31/24, completed by MD B reflected:</p> <p>Chief Complaint: Resting in bed. Pt with 8/10 achy L shoulder and BL knee pain, worse with activity, would like BL knee injections. Pt denied any CP. Pt denied any Shortness of Breath. Pt with no bowel incontinence. Pt with bladder incontinence. Gait [walking]: 70 ft RW CGA [rolling walker with care giver assist] .</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Physical Exam .[Extremities] No LE edema appreciated, no atrophy [wasting of muscle mass] appreciated in all 4 extremities. MSK: At least 3/5 in all 4 extremities except 2/5 in L shoulder .BL LE movement slow .</p> <p>Assessment .Has 7/10 achy L-sided pain from fall, worse with activity, Tylenol helps. Incontinent of bowel and bladder.</p> <p>Plan: Physical Therapy .Needs to work on gait distance. Will try knee injections .</p> <p>Pain: L shoulder pain c/w DJD vs labral tear [injury to tissue that holds joint together].</p> <p>BL knee pain, XRs with DJD.</p> <p>Therapy for pain modalities.</p> <p>Gabapentin, Tylenol, Lidoderm.</p> <p>Will order injection meds.</p> <p>Monitor for side effects</p> <p>Record review of Resident #389's SNF Rounding Note dated 02/02/24, completed by MD B reflected:</p> <p>Chief Complaint: BL knee pain. Yesterday I received a call that the injection meds that I ordered for her BL knees were injected by the nurse without authorization or my approval. After several discussions with DON and ADON, it seems that the nurse administered Kenalog and Lidocaine to the pt's L shoulder and R lateral knee sometime between 1/31/24 and 2/1/24. Since receiving the injections, pt is able to use her LUE more and states that the shaking in her L hand had greatly improved. Pt stated that she only remembered getting a L shoulder injection, not any knee injection. Pt with up to 8/10 achy BL knee pain with gait, better with rest. Denies any L shoulder pain but reports occasional L upper arm pain with ROM, which has been ongoing since she fell . Pt denied any CP. Pt denied any shortness of breath .</p> <p>Physical Exam .[extremities] No LE edema [swelling caused by fluid] appreciated. No atrophy appreciated in all 4 extremities. No L shoulder joint tenderness or warmth. No needle sit [sic] appreciated. No deformity or erythema [redness] BL knees with no tenderness or erythema. No increased warmth compared to rest of LEs-Res spot that looks like a needle mark at R lateral/superior lower leg, just below knee. No surrounding erythema or tenderness. MSK: At least 3/5 strength in all 4 extremities. No abnormal tone in all 4 extremities. BL LE movement slow. Full active ROM in L shoulder, even with R shoulder .</p> <p>Plan .</p> <p>Pain: L shoulder pain c/w DJD vs labral tear.</p> <p>BL knee pain, XRs with DJD.</p> <p>Therapy for pain modalities.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Gabapentin, Tylenol, Lidoderm [oral and topical pain medications].</p> <p>L shoulder Kenalog/Lidocaine injection performed by nurse (without my authorization) and possible a R knee /proximal gastroc [muscle near the knee] injection. I am unaware of how much was injected and what techniques were uses [sic] to minimize the possibility of infection. I instructed the DON and ADON to inform the family, which they said they have. They also said that the incident has been reported to the state and board of nursing. There does not seem to be any infection at this time or any MSK damage. Function is not only intact but improved in the L shoulder. Gait distance is improved as well. I have no plans to administer any further injections at this time. If needing any injections, I recommend she consult her PCP for possible referral to Pain or Ortho. Will continue to monitor function and for any possible infection. Discussed with nursing about monitoring for redness, increased pain or fevers. Monitor for side effects</p> <p>Record review of Resident #389's Progress notes revealed the following entries:</p> <p>01/31/24 3:17 PM: New order CBC, CMP, Magnesium STAT Signed by LVN A</p> <p>01/31/24 4:18 PM: Order called in Signed by LVN A</p> <p>There were no other entries were made by LVN A after 01/31/24.</p> <p>02/01/24 10:50 PM: Resident is alert and awake, no acute distress noted. No present concern at this time. Respiration even and unlabored. Resident expresses no other needs at this time. Call light within reach. Plan of care ongoing. Signed by LVN H.</p> <p>02/02/24 5:10 PM Physician Progress Note: Chief Complaint: Follow-up Medical evaluation.</p> <p>HP [history/physical]: [Resident #389] is a 75 y.o. female with PMHx significant for chronic back pain, diabetes who was admitted to [hospital name] on 12/27/23 after being found down by family. Patient had possible sepsis and was started on empiric antibiotics. Chest x-ray revealed right upper and lower lobe pneumonia and was found to have elevated LFT [liver function tests] as well. She was given IV fluid with some subsequet improvement but remained very weak so she was discharged to [nursing facility name] for continues care and therapy.</p> <p>Today's Visit: Incident note with nursing staff. Order blood work to monitor for infection .stated that her overall pain is about the same and is a chronic pain Signed by MD C.</p> <p>02/09/24 11:05 AM: Resident discharged home in stable condition</p> <p>During an interview on 04/16/24 at 8:25 AM, the DON stated she did not believe there were any current residents in the facility who had orders for intra-articular injections but would confirm with the pharmacist and MD B.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 04/17/24 at 6:40 AM, the CNO was asked to provide any additional training material or information related to the incident involving Resident #389 as well as contact information for the staff and physicians involved. She stated the resident was seen the next day by her physicians and no adverse reactions were found. She stated they were never able to determine the volume of the injections administered and she would gather any additional information she could locate. The CNO stated there were no current orders for intra-articular injections and no medications being held for such in the facility. She stated, the normal procedure for intra-articular injections was, MD B ordered the medications he intended to use from the pharmacy and the medications would be locked in the medication cart. She stated MD B would retrieve the medications from the cart when he arrived to perform the procedure.</p> <p>Observations during medication pass on 04/17/24 from 7:00 AM through 8:25 AM revealed medications were administered by RN F, RN G, and LVN D. Medication route observed included subcutaneous injection, enteral feeding tube, nasal spray, transdermal patch, and oral administrations. No medication errors were observed.</p> <p>During a follow-up interview and record review with the DON on 04/17/24 at 8:54 AM, she stated she had confirmed there were no medications for intra-articular injections in the facility. She stated she spoke with MD B and he confirmed he had no recent or pending orders for the injections. She provided MD B's progress notes retrieved from Resident #389's clinical record. The Facility Investigation Report and MD B's progress note were reviewed with the DON. She reviewed MD B's progress note dated 02/02/24 and stated he had been called immediately after learning of the incident on 02/01/24. She stated she had left the facility for the day. LVN A had reported the incident to the ADON who immediately notified the CNO. She stated LVN A was immediately removed from the floor and brought in for questioning. She stated the ADON had assessed the resident and brought the Admissions Staff member with him for translation. She identified the Admissions staff member and stated she no longer worked for the facility. The DON stated she assessed Resident #389 the next morning and did not recall seeing a puncture mark on her knee. She thought she recalled seeing a small puncture mark on her shoulder but could not recall the exact location. She did not see any swelling, puffiness, or bruising. She stated Resident #389 had denied getting an injection in her knee. The DON stated she and the CNO had interviewed LVN A again the next day and asked about the injection to the shoulder. The DON said she remembered LVN A saying she gave it like Retacrit [a medication for anemia administered subcutaneously]. When asked if they had attempted to get a written statement from LVN A, the DON stated they could never get a straight story from her, when they asked her why she injected Resident #389's arm she just sat silent. The MAR was reviewed, and the DON was asked if they had ever determined the time of administration. The DON stated she had noted the medication was signed out around 10:00 AM. She stated LVN A worked the 6:00 AM-2:00 PM shift and had reported the incident around 3:30 PM-4:00 PM. She stated staff were supposed to sign out a medication at the time of administration, but they could never get an exact time of administration from her. The DON stated she immediately initiated in-service training for all nursing staff which included a review of medication administration policy/procedures and scope of practice for RNs and LVNs. She stated MD B had previously administered the injections in the facility and nothing like this had ever happened before. She stated he told her he would continue to make it very clear on his orders to hold the medications for him. She stated, we are always telling the nurses, any questions at all about medications, stop what you are doing and ask us, the doctor, the pharmacist, just ask. She stated the risks included she could have hit a nerve, caused an infection or other injury. The DON stated Resident #389's discharge home was unrelated to the incident and had already been in the planning process.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During a telephone interview on 04/17/24 at 9:33 AM, LVN A declined to answer any questions related to the incident.</p> <p>During an interview on 04/17/24 at 9:30 AM, MD B confirmed he had been notified of the incident involving Resident #389 receiving injections from a nurse which he had intended to administer by intra-articular injection. MD B stated he assessed Resident #389 the next morning. He stated he did not have his notes in front of him and referred this state surveyor to his progress note for 02/02/24. He stated he did not recall seeing any damage or injury and stated, she actually seemed to have improved functionality, no sign of infection. He stated he did not recall seeing anything abnormal and he was not overly concerned with injury. MD B stated he typically administered the intra-articular injections and was the only person who did them. He stated he had been conducting rounds in the facility since the summer of 2016 and had been doing the injections since that time. He stated he had never encountered anything like this incident before. MD B stated the medications had always been kept in the medication cart for him and he personally ordered the medications and added the note to hold the medications for him. He stated, This was a shock. They called me immediately when they found out, and I came in the next day to assess her. He stated he had instructed them to monitor her and call him with any concerns. MD B confirmed he had no current orders for any other resident and could not recall when he had performed his last injections. He stated the injections were infrequent. He stated he probably performed 3-4 injections per month over three different facilities he covered so maybe 1 injection every 3 months or so at this facility. MD B stated whenever he performed the intra-articular injections, he had the residents sign a consent form and discussed the risks with the resident. He stated the main risk for Resident #389 was infection as he was unable to tell what process she used to prepare the area. He stated injection risks included muscle damage, tendon, and nerve damage. He stated, with the shoulder, there is a brachial plexus nerve or lung that could be damaged depending on where she inserted the needle. He stated he could not recall if he saw a puncture mark. He stated he had no clear picture of how much of each medication was injected at each site. MD B stated he thought the resident told him only her shoulder was injected.</p> <p>(continued on next page)</p>		

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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.			
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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During a telephone interview on 04/17/24 at 10:30 AM, Resident #389 stated she had had a fall at home in December 2023, was hospitalized , and ended up in the nursing facility for therapy. She stated she was having arm pain in the past due to arthritis but, after her fall, she had increased pain in her arm and knees. She stated, around 4:00 PM that day, a nurse arrived and told her she was going to give her a shot. She was not certain of the exact time but stated it was after lunch and her therapy. She told her ok because she thought it was her insulin, but then saw she had various injections and could not recall how many. She stated the nurse told her she was going to give her a shot in the shoulder and knee. Resident #389 stated the doctor had already told her he was going to give her shots and she thought maybe he sent the nurse instead. Resident #389 stated the nurse injected her shoulder and it hurt very bad and never gave her a shot in her knee. She stated the nurse stayed to monitor her for a bit then took the rest of the injections and put them in the red box disposal. Resident #389 stated she asked the nurse if she was going to give her a shot in her knee and she did not answer. She stated she asked her three times in English with no response. Resident #389 stated on the third time, when she did not answer, she thought maybe it was not her day for her shot. Resident #389 stated later, around 6:00 PM, staff approached her and asked if she was doing ok. She stated her arm was feeling better, she was moving it better, and it was not shaky anymore. Resident #389 stated they asked her about her knee, and she told them it was still hurting, that the doctor told her she would get a shot in her shoulder and knee, and she only got one in her shoulder. She stated she told them she did not understand why the nurse only used one injection and she did not know why she had so many injections with her. She stated she did not know why the nurse told her she was getting a shot in her shoulder and knee, then only injected her shoulder. Resident #389 stated they got the nurse and brought her to her room. She stated the nurse was crying and yelling Tell them I gave you a shot in the knee! and was being dramatic. She stated she told the nurse No, you didn't give me a shot in the knee. She stated she did not understand why the nurse said she did, she stated she was not demented, and remembered the incident. Resident #389 stated she believed the nurse was being dramatic because she was told only the doctor should have given her the injection. She stated that was the first time a mistake had been made. She stated she felt like the staff thought she was lying but she knew what she got. Resident #389 stated her doctor came to see her the next day and was upset about the situation.</p> <p>During an interview on 04/17/24 at 12:00 PM, the Administrator stated LVN A was pulled immediately from duty when she reported the incident and was terminated shortly after. He did not recall whether anyone took her back to Resident #389's room after the incident.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 04/17/24 at 12:08 PM, the CNO stated she was working in the facility on the day of the incident. She stated the ADON brought the nurse in to her and said, We have a problem, she administered [MD B's] injection. The CNO stated she started asking her what?, where?, why? She said it obviously stated on the order to hold for MD B. The CNO stated the ADON left to check on Resident #389 while she interviewed the nurse. He returned and told her the resident stated she had only been injected in her shoulder. She stated LVN A originally told them she had injected her knee. She stated LVN A kept going back and forth on her story and it did not match the resident's statement. She stated she finally told LVN A, come and show me, at which time LVN A began to cry, got on her knees, and said, I'm sorry, I don't know why I did that. She stated she was not sure if the ADON took LVN A to the resident's room for clarification and the two of them were quickly trying to investigate and contact her physicians. She stated when she asked LVN A why she injected her shoulder when that was not even part of the order, she replied, 'because her shoulder hurt'. The CNO stated she told her, So, basically you played doctor. She stated she told her at that time she was going to be terminated and her license would be referred. The CNO stated the Human Resources (HR) staff was not there at that time so the next day she had them terminate her employment. She stated she had never encountered anything like this before. She stated she did part of the HR portion, initiated a State report and the BON referral. The CNO stated they were never able to clarify the time the incident occurred because she did not have the MAR in front of her at the time of her interview. She stated, there was so much back and forth, she did not know what was true and what was not. She stated Resident #389's attending physician and MD B were contacted as well as her family. The ADON completed a physical assessment and initiated ongoing assessments to monitor for any adverse reactions. She stated she believed both physicians saw her the next day. The CNO stated LVN A had received the normal training and skills check-off that all nurses receive. She stated reading a physician's order was a basic nursing skill, and the instructions were added to the order and MAR specifically for that purpose. She stated there was no specific training for this particular situation because the physician brought all his own equipment, retrieved the medications, and took care of everything himself. She stated the risks included adverse effects from the medication, infection, and nerve injury. The CNO stated the DON immediately prepared and initiated in-services and went specifically in-depth regarding MD B's orders. She stated she also included handouts from the BON related to nurse's scope of practice.</p> <p>On 04/17/24 at 12:40 PM, an attempt to reach the ADON for a telephone interview was unsuccessful.</p> <p>During an interview and record review on 04/18/24 at 10:55 AM, the OT reviewed her notes and stated she had cared for Resident #389 during the first week of April 2024. She stated she had heard about the incident involving her injection and the resident had told her she had received an injection in her shoulder but not her knee. The OT stated they always checked for swelling in the joints and she did not recall seeing any swelling or bruising on her. She stated Resident #389 did well during her therapy on 02/02/24 and was ambulating with her walker. She stated she had already been progressing well toward her discharge goal when the incident occurred.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>An interview with LVN H on 04/18/24 at 8:50 AM revealed she had cared for Resident #389 on 2/1/24 during the evening shift. LVN H stated she was aware of the incident that had occurred but had not witnessed anything. She stated she recalled the resident telling her as well as receiving orders to monitor her closely for any reactions like swelling, redness, or increased pain. She reviewed her notes and stated she did not recall Resident #389 having any complaints that evening. LVN H stated she had attended the in-service training the next day related to medication administration and scope of practice. She stated, as an LVN, she was only allowed to administer intramuscular and subcutaneous injections. She stated she had additional training to administer intravenous medications. LVN H stated it would never be appropriate to administer intra-articular injections as only physicians could administer those. She stated she knew to call her manager if she had any questions related to her medication orders</p> <p>The non-compliance was identified as past non-compliance. The Immediate Jeopardy (IJ) began 02/01/24 and ended on 02/02/24. The facility corrected the non-compliance before the survey began.</p> <p>The facility took the following actions to correct the non-compliance prior to the investigation:</p> <p>Record review of LVN A's personnel file revealed a Termination of Employment Statement dated 02/02/24, which shows LVN A's employment had been terminated on 02/02/24. The document was signed by the DON and the Administrator.</p> <p>Record review of a Complaint Form dated 02/02/24 revealed the CNO submitted a referral to the Texas Board of Nursing related to the actions taken by LVN A.</p> <p>Record review of the following in-services dated 02/02/24 reflected: Topic: Medication Administration. Contents or summary of training session: Medication Administration, Following physician orders and direction, reporting. See attached Conducted by the DON. A Signature sheet was attached and included named of the nursing staff.</p> <p>The attached training materials included:</p> <p>Bulletproof Medication Administration 1. Right Patient check two unique identifiers such as name and birthdate, or name and medical record number. Ask the patient whenever possible. 2. Right Medication-Never assume .always look at your medication to make sure it's the right one. Many medications look and sound alike. 3. Right Time-verify your institution's policy for the timeframe to give scheduled meds; double-check PRN intervals to ensure patient safety. 4. Right Dose-If you're unsure of your dosage, ask another nurse to verify. If you're ever opening multiple packages or vials .check again! 5. Right Route-Some meds can be given via multiple routes, and oral liquid meds should never be given IV. 6. Right Indication-Understand why your patient is receiving each medication. It will help you understand their condition and alert you to what you need to monitor. 7. Right Formulation-Some medications come in different formulations such as tablets, elixirs, or suppositories. Tylenol is a great example of this! 8. Right Documentation-Document immediately when giving medication and be sure to include any pertinent data such as vital signs or pain scores. 9. Right Response-You must understand what response you are expecting from each of the medications, so you know if they are effective or not. 10. Right Compatibility-Ensure any IV medications running together are compatible. Also, give enteral medications one at a time. 11. Right Contraindications-Know what situations would cause you to hold the dose. This may be vital signs, physiologic conditions, or even an allergy.</p> <p>(continued on next page)</p>		

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