

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 05/16/2025
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 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 3 Residents (Residents #99) reviewed for respiratory care.</p> <p>The facility failed to promptly notify emergency services when Resident #99 developed respiratory distress following incontinence care on [DATE] at 2:00 PM. The resident's oxygen saturation was 66% and he was on 5 liters of oxygen via nasal cannula. The resident remained in respiratory distress until emergency medical services arrived at 2:45 PM on [DATE] and transferred him to the hospital.</p> <p>An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 11:00 AM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because all staff had not been trained on [DATE].</p> <p>This failure could place residents requiring respiratory care at risk for exacerbation of condition up to and including death.</p> <p>The findings included:</p> <p>Record review of Resident 99's admission MDS assessment, dated [DATE], revealed the resident was a [AGE] year-old male admitted on [DATE]. His diagnoses included heart failure, renal failure requiring dialysis, chronic obstructive pulmonary disease (lung disease), and respiratory failure. The resident's BIMs score was 14 indicating the resident was cognitively intact. The resident received oxygen.</p> <p>Record review of Resident #99's physician orders, dated [DATE], reflected:</p> <ol style="list-style-type: none"> Code Status: Full Code. Oxygen @ 5 Liters per minute via nasal cannula as needed to maintain oxygen saturation at 92%. <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 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>2:00 PM The resident was almost finished with incontinence care that WCN B and CNA C had been providing. Resident #99 said he was having trouble breathing. The resident had oxygen at 5 liters per nasal cannula. WCN B repositioned the resident and left the room to notify LVN A. CNA C went to the resident's room door. Resident #99 was in respiratory distress. The resident was using his accessory muscles to breathe, he closed his eyelids halfway, he would rouse when spoken to and say he was ok,, but his respirations were rapid in the 30's. There was no nurse with the resident. The resident had a bi-pap machine in his room.</p> <p>2:06 PM LVN A entered Resident #99's room. The resident remained in respiratory distress. LVN A donned PPE. LVN A then started taking vital signs.</p> <p>2:11 PM LVN A was able to get a temperature of 97.1 degrees Fahrenheit, a pulse rate of 112, and an oxygen saturation of 66%. LVN A and CNA C repositioned Resident #99 to sit straight up. The oxygen saturation improved to 70%. The resident continued to be in respiratory distress. The resident continued to say he was ok even though he was not. LVN A left and said he was going to call the doctor.</p> <p>2:12 PM Resident #99 continued to be in respiratory distress. His oxygen saturation was 70%. He had a congested cough and his respiratory rate remained in the 30's.</p> <p>2:17 PM LVN A returned to Resident #99's room and started a breathing treatment for the resident. LVN A removed the pulse oximeter and left the room saying he was going to call the doctor again. The resident was struggling to breathe, respirations 30, heaving to breathe, nebulizer treatment continued. There was no nurse in the room, the resident had his eyes closed.</p> <p>2:29 PM LVN A re-entered the room. LVN A checked, and the resident's oxygen saturation reached 85% at the highest point and the pulse rate was 113. LVN A said the doctor ordered a chest x-ray and labs. The resident continued to be in respiratory distress. The resident's oxygen saturation began dropping rapidly to 82%, 79%, and 77%. LVN A left the room and said he was calling the doctor.</p> <p>2:37 Resident #99's oxygen saturation was at 76%, and his pulse rate was 114. The resident continued to be in respiratory distress.</p> <p>2:40 PM ADON D entered the resident's room and had an oxygen tank and non-rebreather mask with her. Resident #99's oxygen saturation was at 75%. The resident's oxygen saturation rapidly rose to 95% after applying the non-rebreather mask. ADON D asked the resident if he felt tightness in his chest and he said no. ADON D stayed in the room with the resident.</p> <p>2:45 PM Resident #99's oxygen saturation was 97% and emergency medical services entered the resident's room and began assessing him.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview on [DATE] at 03:01 PM with LVN A revealed his shift started at 2:00 PM and that he did not enter Resident #99's room until 2:06 PM because his shift had just started. LVN A said he did not know how long the resident had to wait to get increased oxygen, but that he gave the resident a nebulizer treatment. LVN said if a resident had a low oxygen saturation, then he was supposed to give the resident oxygen, sit them up, and notify the doctor. He said the process should take no more than 15 minutes. LVN A said it took longer than that this time, because he thought the resident was ok, because the resident said he was, ok. He said he did not know why the oxygen saturation showed something different. LVN A said he thought the resident's respiratory rate was about 22 breaths/minute and the resident was using his accessory muscles to breathe, but the resident said he was, ok. LVN A said he thought the resident's oxygen saturation increased to 88 or 89%, not 85%. LVN A said he had been trained to call 911 but did not because the resident did not have respiratory distress until staff laid him down to provide care. LVN A said the nurse was supposed to wait with the resident, but he was not able to because he had to call the doctor. LVN A said he could have called ADON D, but she was in another resident's room. LVN A said a resident who remained in prolonged respiratory distress could develop respiration failure and death.</p> <p>An interview on [DATE] at 2:50 PM with ADON D revealed she did not know how long Resident #99 was in respiratory distress before she arrived and gave him increased oxygen. She said if a resident reported shortness of breath, then the nurse was to check the resident's vital signs, evaluate breath sounds with a stethoscope, assess to see if resident was using accessory (muscles to breathe) and check the resident's diagnosis. She said if she had known Resident #99 had an oxygen saturation of 66% she would have given him a breathing treatment, notified the physician, and called 911.</p> <p>An interview on [DATE] at 4:12 PM with WCN B revealed she knew Resident #99 was in respiratory distress during incontinence care because he said he needed to catch his breath, started having trouble breathing, and said he was, ok, but he was not. WCN B said she immediately sat him up and raised his head of bed and notified LVN A. She said she did not know how long he remained in respiratory distress and did not know what his oxygen saturation was. WCN B said if a resident had respiratory distress, the nurse was to check the airway and the oxygen level. She said if the oxygen saturation was less than 90% or if the resident had chronic obstructive pulmonary disease, then it might get as low as 88%. WCN B said the nurse needed to know the resident's orders, call rapid response and the physician. WCN B said she did not know it took 40 minutes for Resident #99 to get relief and if she had known it was going to take that long, then she would have stayed with the resident and taken care of him herself. WCN B said if a resident was in respiratory distress, then you could call for help from the ADON and DON and 911 if needed, but the nurse had to stay with the resident. She said a resident would be at risk of death if they continued to have respiratory distress.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview on [DATE] at 3:16 PM with the DON revealed she was familiar with Resident #99. She said she saw the resident in the morning on [DATE] before the resident went to dialysis. She said she was told Resident #99 was in respiratory distress at around 2:00 PM and was at the nurse station (directly next to Resident #99's room). She said she did not see LVN A and that he must have been in Resident #99's room. The DON said if a resident was in respiratory distress, the nurse was supposed to elevate the head of the bed, notify the physician, and make sure the resident had oxygen. The DON said she never went into the resident's room to assess because she was at the nurse station working on paperwork to send the resident to the hospital. The DON said LVN A did what he was supposed to do and she did not see anything wrong with the actions of LVN A. She said he had to call the doctor to get an order for a breathing treatment. The DON said LVN A gave the treatment, reassessed the resident, but the resident's oxygen saturation was dropping. The DON said she did not know the resident already had orders for breathing treatments as needed. The DON said Resident #99 had shortness of breath, the nurse intervened, the nurse notified the physician, performed the interventions, but the interventions were ineffective. The DON said LVN A followed the physician orders. The DON said the nurse could call 911 only after notifying the physician unless the resident was unresponsive. The DON said the situation did not require LVN A to contact 911 until after he performed the ordered interventions. The DON said a resident with prolonged respiratory distress could develop hypoxia (life threatening condition when there are low oxygen levels), and further respiratory distress.</p> <p>An interview on [DATE] at 4:39 PM with the FNP revealed she was the provider for Resident #99 and that LVN A had contacted her when the resident was in respiratory distress. The FNP said she was contacted by LVN A at 2:14 PM and was told that during care the resident claimed he had shortness of breath. She said LVN A did the appropriate nursing interventions and was told his oxygen saturation had recovered, and he had a little tachycardia (rapid heart rate). The FNP said she gave an order for a chest x-ray as long as the resident was not in distress. The FNP said LVN A called her back at 2:37 PM and said Resident #99's oxygen saturation had dropped. She said she did not know it took 40 minutes to get the resident relief. She said she was not told that the resident was using his accessory muscles to breathe, and he was heaving his chest to breathe. She said if she had known that, then she would have told LVN A to call 911. She said a resident with continued respiratory distress could lead to cardiac arrest and death. The FNP said she did not know the status of the resident in the hospital because she did not have hospital privileges.</p> <p>An interview on [DATE] at 10:01 AM with the family of Resident #99 revealed he was in the ICU at the hospital and they were monitoring his breathing.</p> <p>Interviews on [DATE] at 10:05 AM and 10:35 AM with the DON revealed she did not know the status of Resident #99. She said the family called on the night of [DATE] and thought the resident had overexerted himself. Additionally, the DON said the facility did not have a rapid response policy, because each resident situation was different.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview on [DATE] at 6:15 PM at the hospital with Resident #99 revealed he was breathing without distress. He was wearing oxygen and said he was doing very well. His Hospital RN said he was on IV antibiotics but did not know if he had pneumonia or another type of infection. The Hospital FNP was in his room and said he admitted to the hospital with acute hypoxic respiratory failure and said that when the resident went into respiratory distress at the facility, he should have been placed on bi-pap. The FNP said due to the resident's diagnoses he had a hypoxic drive to breathe (hypoxic drive to breathe is a physiological mechanism that stimulates breathing in response to low oxygen levels in the blood, particularly significant in patients with chronic lung diseases like COPD.) The FNP said the resident was supposed to be placed on bi-pap immediately after finishing his dialysis treatments. The FNP said the resident needed a respiratory therapist to monitor him at the facility and she said she made it clear to the facility before he was admitted to the facility that he had to have respiratory therapy as well as a bi-pap machine.</p> <p>Review of the facility policy, Acute Condition Changes - Clinical Protocol, revised [DATE], reflected:</p> <p>Assessment and Recognition</p> <ol style="list-style-type: none"> 1. The physician will help identify individuals with a significant risk for having acute changes of condition during their stay; for example, an individual with an indwelling urinary catheter who has had recurrent symptomatic urinary tract infections, or someone with unstable vital signs or recurrent pneumonia. 2. In addition, the nurse shall assess and document/report the following baseline information: <ol style="list-style-type: none"> a. Vital signs; b. Neurological status; c. Current level of pain, and any recent changes in pain level; d. Level of consciousness; e. Cognitive and emotional status; f. Resident's age and sex; g. Onset, duration, severity; h. Recent labs; i. History of psychiatric disturbances, mental illness, depression, etc.; j. All active diagnoses; and k. All current medications . <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Root-cause identified that re-education of the Professional Standards of Respiratory Care process was needed.</p> <p>Systematic Approach:</p> <ol style="list-style-type: none"> 1. LVN A was educated on [DATE] and received one on one education on [DATE], prior to working his next shift, regarding acceptable standards of practice for residents in respiratory distress. Education was completed by the Chief Nursing Officer. Weekly education will continue for LVN A for four weeks completed by the Director of Nursing/Designee and will be monitored for understanding and implementation of knowledge. 2. The facility began education to all licensed nursing staff and certified nurse aides on [DATE] regarding acute change in condition including residents experiencing respiratory distress. Education being completed with all licensed nurses and nurse aides by the Director of Nursing/Designee, RN. 3. The facility completed an audit on [DATE] of all patients that require respiratory treatment to ensure care plans and standards of practice were updated and followed. There were no identified patients in the facility that required changes. 4. The Director of Nurses/Designee will continue to educate new staff upon hire and monthly for 3 months on providing respiratory care according to professional standards of practice. 5. The facility contracted Respiratory Therapist will conduct ongoing monthly training and education for all licensed nurses beginning [DATE] to ensure professional standards of practice are followed for respiratory care needs. 6. An emergency QAPI meeting was completed on [DATE] by the Executive Director regarding respiratory care. The QAPI team determined that best practices would include notifying 911 to transfer a resident to the hospital for respiratory distress that resulted in oxygen saturation below 70% regardless of overall status. Any resident showing signs of respiratory distress would prompt the nurse to begin immediate interventions while remaining at the bedside of the resident and calling the Medical Doctor. 7. The Director of Nursing/Designee will monitor all current patients and newly admitted patients that require respiratory care for appropriate treatment and services. <p>Monitoring of the facility's Plan of Removal included the following:</p> <p>Record reviews of the facility Plan of Removal In-services reflected:</p> <p>11 staff were in-serviced on:</p> <p>Emergency Intervention for Residents in Distress During Respiratory Distress, dated [DATE], reflected:</p> <p>Purpose</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>or 911 is activated.</p> <p>5. Initiate Emergency Response (if needed)</p> <p>o If resident becomes nonresponsive, deteriorates, or SpO₂ drops critically:</p> <p>Activate Emergency Medical Services (911).</p> <p>Initiate CPR if resident is pulseless and DNR is not in place.</p> <p>Follow facility's Code Blue protocol.</p> <p>6. Medication Administration</p> <p>o Administer prescribed PRN [as needed] respiratory medications (e.g., bronchodilators, inhalers, nebulizer) as ordered.</p> <p>o Ensure respiratory treatments (e.g., albuterol) are started immediately per standing or emergency orders.</p> <p>7. Documentation</p> <p>o Record all observations, interventions, time of events, vitals, oxygen use, medication administered, and communication with physician/family.</p> <p>o Document resident's response to interventions.</p> <p>o Complete incident report if EMS is called or acute change occurs.</p> <p>8. Staff Training and Competency</p> <p>o All staff must be trained in:</p> <p>Recognition of respiratory distress</p> <p>Use of pulse oximetry</p> <p>Emergency oxygen delivery</p> <p>Facility's emergency protocols</p> <p>15 staff were in-serviced on:</p> <p>Change of Condition, dated [DATE], reflected:</p> <p>Utilizing SBAR [document used to communicate with physician - situation, background, assessment, and recommendation.]</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 05/16/2025
NAME OF PROVIDER OR SUPPLIER Villages of Lake Highlands		STREET ADDRESS, CITY, STATE, ZIP CODE 8615 Lullwater Dr Dallas, TX 75238	

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Situation - What is happening with the resident?</p> <p>Background - What is the clinical background of resident?</p> <p>Assessment - What does it appear the problem is?</p> <p>Recommendation - How can condition be resolved?</p> <p>When change of condition is reported or noted, nurses should respond with a sense of urgency and quick response to minimize risk of negative outcomes.</p> <p>Anyone with O2 sats 70% or less, call 911 stat.</p> <p>Observations on [DATE] from 1:17 PM to 1:26 PM revealed Residents #1, #2, and #260 were doing well. They were on ordered oxygen therapy and were not in respiratory distress.</p> <p>Interviews with staff from [DATE] at 4:48 PM to [DATE] at 1:35 PM were completed. 13 staff were interviewed in person/on the phone who worked all shifts at the facility. The interviewed staff were LVN A, ADON E, LVN F, LVN G, LVN H, LVN I, LVN J, RN K, LVN L, LVN M, LVN N, RN O, and LVN P. The staff were able to verbalize they were in-serviced on the new Respiratory distress protocol, the SBAR tool, and acute condition changes. The nurses said in order to call 911, the resident needed to be in respiratory distress and not responding to treatment. The nurses said they had to call 911 anytime a resident's oxygen saturation was below 70% but did not have to wait until it was below 70%. The nurses said they had to stay with a resident who was in respiratory distress and did not have to call the doctor before calling 911.</p> <p>An interview with the DON on [DATE] at 12:52 PM revealed LVN A was educated on [DATE] and received one on one education on [DATE], prior to working his next shift, regarding acceptable standards of practice for residents in respiratory distress. The DON said he would receive weekly education that would include response to emergency situations, actions to take, elevate head of bed, and respiratory distress. She said LVN A would be understood that if a resident was in extreme distress, he was to send them out, stay with the resident in room, and alert people to help him. The DON said the majority of the nurses had been in-serviced and everyone would be in-serviced prior to their next shift. The DON said the facility completed an audit on [DATE] of all residents that require respiratory treatment to ensure care plans and standards of practice were updated and followed. The DON said there were no issues identified and she would ensure all new admits had the right orders and treatments. The DON said going forward, if she was notified that a resident was in respiratory distress she would go to the hall and help assist with the resident.</p> <p>An interview on [DATE] at 12:33 PM with the Administrator revealed he would monitor to ensure that all staff were trained on providing respiratory care according to professional standards of practice. The Administrator said he had an emergency QAPI meeting focusing on respiratory issues. He said his expectation for nursing leadership was for them to intervene if a resident was in respiratory distress, but that all staff were trained to respond to a resident in respiratory distress.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 11:00 AM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because all staff had not been trained on [DATE].</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for the facility's two (400 and 500 halls) of four medication cart reviewed for storage.</p> <p>The facility failed to ensure Residents #23, #13, #68's insulin lispro vials, Resident #95's insulin lispro pen, Resident #103's glargibe-yfgn insulin vial and Resident #68 Tresiba flex touch insulin were dated when opened.</p> <p>This failure could affect residents and staff resulting in diminished effectiveness, and not receiving the therapeutic benefits of the medications.</p> <p>The findings included:</p> <p>Observation on [DATE] at 12:21 PM with LVN Q in the 400-hallway's medication cart revealed vials of insulin and insulin pen without an open date. The insulin lispro 100unit/ml vials were for Residents #23, #13, and #95. The insulin lispro 100units/ml pen was for Resident #95</p> <p>In an interview on [DATE] at 12:24 PM with LVN Q, he stated he was not aware why the insulins were not dated. He stated he had used some on the undated insulin and did not realize they did not have open date. LVN Q stated the insulins were supposed to be dated when they were opened because they were good for 28 days before they expire. LVN Q stated insulin was to be dated to make sure expired medication was not administered to the residents because the medication could not be effective to the residents and could cause negative drug effects.</p> <p>Observations on [DATE] at 12:26 PM with RN K in the 500-hallway's medications cart revealed vials of insulin without the open date. The insulin lispro 100unit/ml vial and Tresiba Flex touch 100 units/ml vial for Resident #68.</p> <p>In an interview on [DATE] at 12:30 PM with RN K, she stated she was not aware why the insulins were not dated. She stated it was the responsibility of every nurse to check the open date for the insulin being administered but she failed to. RN K stated insulin was supposed to be dated because it was good for 28 days after open date, so without the open date, the staff might administer expired insulin which could not be effective or cause negative side effects. RN K stated normally the pharmacist will check for expired medication in the cart.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on [DATE] at 10:51 AM with the DON, she stated she had been informed of the medication's carts containing undated insulin. She stated after the report the facility had audited all the medications carts to make sure there was no undated insulin. The DON stated she expected the charge nurse to check and make sure the insulin being administered had an open date and discarded after 28 days. The DON stated the pharmacists checked the carts to make sure the insulins were dated but it was the responsibility of the nurse to make sure the insulins had an open date when administrating. The DON stated she completed random checks of the cart, and she did not have a schedule when she checked. The DON stated undated insulin could be expired which could decrease effectiveness of the insulin when used by the resident.</p> <p>Review of the facility policy revised February 2023 and dated Medication Labelling and Storage reflected, Medication Labelling.</p> <p>1.</p> <p>Labelling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices.</p> <p>2.</p> <p>Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 6 residents (Resident #209) reviewed for infection control.</p> <p>LVN R failed to wear the appropriate PPE while assessing Resident #209's wound.</p> <p>This failure could place residents at risk of being infected by staff in contact with other residents with infections.</p> <p>Findings included:</p> <p>Review of Resident #209's face sheet dated 05/16/25 revealed she was a [AGE] year-old female, she was admitted on [DATE]. Admitting diagnoses included, endocarditis, type 2 diabetes, end stage renal failure and hypertension.</p> <p>Review of Resident #209's care plan dated 05/13/25 reflected, the resident had a diabetic ulcer to left heel related to diabetes. Goal, the resident will have no complications related to ulcer.</p> <p>Review of the Resident #209's orders summary dated 05/16/25 for the month of May reflected, an order of enhanced barrier precautions: providers and staff must wear gloves and a gown when performing high - contact resident care activities every shift.</p> <p>Observation on 05/13/25 at 09:47 AM revealed LVN R enter Resident #209's room without a gown. On the door of the resident's room there was a posting indicating the resident was on enhanced barrier precaution. Upon entering the room, LVN R was observed bent over attending to Resident #209's right leg. LVN R stated she was doing the resident's wound care to the leg, and then she proceeded to get the trash that was on the side. The resident was noted having a dressing on the left ankle area. LVN R placed the trash in the trash can and procced to the bathroom and she stated she was going to complete hand hygiene.</p> <p>In interview on 05/15/25 at 02:34 with LVN R, at first, she stated she had gone to check if the resident had a wound, and later she stated it was documented the resident had two wounds and wanted to assess the wounds and provide wound care. When asked if she was supposed to put on PPE, she stated she was supposed to have a gown and gloves on because she was in contact with the resident. LVN R stated she did not have a reason why she did not put on a gown while being in contact with the resident. LVN R stated per facility policy she was supposed to put on PPE for infection control. LVN R stated she had had access to PPE and there were some on the hallway in the cart.</p> <p>In an interview on 05/16/25 at 10:58 AM with the DON, she stated she expected the staff to use PPE while assessing the wound or providing care to the wounds. The DON stated the PPE were available on the hallways. She stated the staff had been in-serviced monthly on PPE use, enhanced barrier precautions, infection control. The DON stated the staff were supposed to have PPE while taking care of residents on enhanced barrier precautions to prevent multi -drug resistant.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy revised August, 2022 and titled Enhanced Barrier Precautions reflected, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents.</p> <p>1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents.</p> <p>2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply.</p> <p>a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room).</p> <p>b. Personal protective equipment (PPE) is changed before caring for another resident.</p> <p>c. Face protection may be used if there is also a risk of splash or spray.</p>