STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676358	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages on MacArthur	3443 N MacArthur Blvd Irving, TX 75062

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054 Based on observation, interview, and record review the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of three residents reviewed for accidents. CNA B failed to follow Resident #1's plan of care when she prepared to transfer the resident without assistance using a mechanical lift. This failure placed all residents, who required 2+ person assist with transfers/mobility, at risk for accidents and injuries. Findings included: Record review of Resident #1's face sheet, dated 09/13/24, reflected the resident was an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: dementia (loss of thinking and memory), psychotic disturbance (mood disorder), Type II diabetes, unsteadiness of feet, lack of coordination, and above the knee amputation of right leg. Record review of Resident #1's Optional State Assessment (OSA) and Quarterly MDS assessment, both dated 08/01/24, reflected the resident required extensive assistance with two+ person assist for bed mobility and transfer. Record review of Resident #1's care plan, dated 05/10/24, revealed the resident was a fall risk related to a fall on 08/08/24, history of heart failure, history of hypertension, and evidenced by amputation, right lower extremity weakness, cognitive status, transfer (total dependence), mobility (immobile) and non-weight-bearing status. Interventions included: assessing and monitoring vital signs, assessing contributing factors related to fall history, assessing for potential fall-related injury prevention, assessing medications for contributing factors, assisting resident with ADLs and toileting as needed, keeping call light and frequently used items within reach, low bed, reminding the resident to call for assistance, and social services and therapy referral, and wheelchair. Further review of care plan reflected the resident also had impaired physical mobility related to history of cardiovascular disease and evidenced by assist rails, right lower extremity weakness, right knee joint pain, and left hip joint pain. Interventions included occupational/physical therapy, providing appropriate level of assistance to promote safety of resident, providing physical assistance to promote highest level of function, and restorative nursing assistance as needed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's incident report dated 08/08/24 completed by LVN A, reflected in part the following: .At about 7:30 AM, an aid was trying to prepare resident to bring her to the dinning [sic] room. As she was trying to but [sic] the sling from the right side, resident roll few [sic] towards the right side of a very low bed, and almost falling. This nurse was in front of her door and ran to help the can [sic] to bush [sic] her back to the bed but very difficult and we lowered her to the grown [sic]. Resident's head accidentally hit the rail the resident stated. This nurse assessed resident and noted a node [sic] to left side of the head . Record review of Resident #1's neurological checks, dated 08/08/24-08/11/24, reflected no changes in the resident's neurological functions. Record review of a 1 to 1 in-service titled Hoyer transfer & Bed Mobility with CNA B, dated 08/08/24, reflected she was educated on proper Hoyer lift transfer and safety of patient and was able to return demonstration. Record review of Resident #1's progress note, dated 08/09/24 by LVN A, revealed the following: [Resident #1] is stable at this time. [Resident #1] in her room and family visiting. [Family] in the building this morning and informed this nurse that [Resident #1] is complaining of pain to the head where the nod [sic] is. This nurse already assessed [Resident #1] at this beginning of the shift and [Resident #1] verbalized pain to the nod [sic] on the head and tender when touch. Pain medication given and order for skull x-ray given. Order called in and awaiting tech. [Family] notified and will F/U with the result. Record review of an in-services titled Nurse Team Meeting Outline on 8/31/24, dated 08/31/24, reflected all staff were educated on multiple topics, including fall prevention. In an interview and observation on 09/12/24 at 4:00 PM, Resident #1 was observed in bed visiting with family. Resident #1 did not have any visible marks or bruises and was well-groomed with no odors. Resident #1 stated she was well and could not recall having any recent falls or injuries at the facility. Resident #1's family stated he was unhappy because last month the facility informed him that Resident #1 had an accident that resulted in a knot and bruise to her head, and it caused her pain a few days following the incident. The family stated CNA B, who was new, admitted to attempting to transfer Resident #1 alone when she fell halfway out of the bed and hit her head. The family stated Resident #1 required a two-person assist with transferring at all times and he did not believe this was being done. The family stated LVN A tried to convince him that CNA B was only preparing Resident #1 for the transfer and was not going to do the actual mechanical lift alone; however, the family stated he did not believe it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/13/24 at 12:29 PM, LVN A stated she worked with Resident #1 on 08/08/24 when the incident occurred. LVN A stated she was standing near Resident #1's door at her cart while CNA B was preparing to transfer Resident #1 to her wheelchair. LVN A stated it was common for the aides to place the transfer sling underneath the residents and prepare them for a mechanical transfer alone, then call for help before performing the transfer. LVN A stated all mechanical transfers had to be completed with at least two staff. LVN A stated CNA B rolled Resident #1 over to slide the sling underneath her bottom and the resident rolled too fast due to having one leg. LVN A stated she rushed to the bedside to help get Resident #1 back in bed. LVN A stated Resident #1 sustained a node on her head after hitting it on the bed rail. LVN A stated she did a head-to-toe assessment, put a cold towel on Resident #1's head, and neurological checks were initiated with no concerns. LVN A stated she notified the MD, DON, and family. LVN A stated Resident #1 was not sent out to the hospital, the MD ordered close monitoring and neurological checks. An attempted interview on 09/13/24 at 12:50 PM with CNA B was unsuccessful due to no response to call. In an interview on 09/13/24 at 12:56 PM, the DON stated it was reported to him that on 08/08/24 CNA B was only preparing Resident #1 to be transferred and LVN A was standing near the door to help when it was time to place Resident #1 on the mechanical lift. The DON stated Resident #1 had lower body weakness due to amputation of her right leg, but she had strength in her upper extremities and was able to hold on to the bed rail to assist staff with bed mobility. The DON stated just as with incontinent care, it was okay for the staff to prepare residents for a mechanical lift by [placing the sling underneath without supervision/assistance; however, the mechanical lift procedure requires two people. The DON stated although Resident #1's MDS assessment indicated that she requires 2+ person assist with bed mobility and transfers, most times the resident only required one-person assist with bed mobility. The DON initially stated he was not sure why Resident #1's MDS assessment indicated that she needed 2+ person assistance with bed mobility. The DON stated immediately after the incident, padding was placed on Resident #1's bed rails and CNA B received 1 to 1 training on transfers and resident safety. The DON stated LVN A documented that Resident #1 was ordered a skull series x-ray; however, it was not completed because the physician decided she did not need one. The DON stated the risk of performing tasks that required bed mobility and transfers with a one-person assist if the resident required a two+ person assist was the resident could fall and/or be injured. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/13/24 at 2:24 PM with the DON and MDS Coordinator, the MDS Coordinator stated she worked at the facility since June 2024. The MDS Coordinator stated Resident #1's MDS assessment did indicate that she required extensive assistance and a 2+ person assist with bed mobility and transfers; however, the MDS was coded based on staff's documentation regarding ADL care. The MDS Coordinator stated if staff documented anywhere at anytime that two or more staff were required to complete a task, it would trigger the code for extensive assistance on the MDS assessment. The MDS Coordinator stated she was responsible for monitoring and updating the MDS Assessments for accuracy and could revise it if changes were needed. The MDS Coordinator stated the codes for assistance were a guide for care and did not mean the residents required that level of care at all times, so although Resident #1's MDS Assessment indicated she required extensive assistance and a 2+ person assist with bed mobility and transfers, it was okay for one staff to assist her when possible. The DON stated the MDS Assessment coding was measured over a 7-day period of performance, and the residents' ability could vary. The DON stated he worked with Resident #1 for many years and knew that she had the strength to assist staff with some tasks, and they encouraged this for Resident #1 to maintain her strength. The DON stated the incident that occurred on 08/08/24 was an accident and likely happened because Resident #1 moved too quickly and not because she was unable to assist with maintaining her balance due to lack of coordination from her amputated right leg. Review of the facility's policy titled Mechanical Lifts, revised 02/12/23, reflected in part the following: Policy: Residents will be assisted with their Activities of Daily living, utilizing lifts according to the manufacturer's guidelines. Procedure: .2. Mechanical Lift Operations a. Introduce self to Resident. b. Verify correct patient using two identifiers. c. Inform resident of procedure. d. Perform hand hygiene. e. Gather necessary equipment and second person to assist Review of CMS's Optional State Assessment (OSA) Manual, dated October 2023, reflected in part the following: Activities of Daily Living (ADL) Assistance 1. ADL Self-Performance: Code for resident's performance over all shifts-not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent-except for total dependence, which requires full staff performance every time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. ADL Support Provided: Code for most support provided over all shifts; code regardless of resident's self-performance classification Definitions: ADL Self-Performance-measures what the resident actually did (not what they might be capable of doing) within each ADL category over the last 7 days according to a performance-based scale. ADL Support Provided-measures the most support provided by staff over the last 7 days, even if that level of support only occurred once