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	02/21/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on interview and record review, the facility failed to incorporate the recommendations from the Preadmission Screening and Resident Record review (PASRR) Level II determination and the PASRR evaluation report for 1 of 3 residents (Resident #2) reviewed for PASRR assessments. The facility failed to submit a NFSS form request by the specific deadline for Residents #2 for therapy services. This failure could place residents at risk of not receiving or benefiting from specialized therapy and equipment services they may require. Findings included: Record review of Resident #2's quarterly MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included cerebral palsy, anxiety disorder, and depression. Resident #2 was not able to complete a BIMS due to her severely impaired cognition. The MDS further reflected the resident was rarely/never understood or rarely/never understood. Record review of Resident #2's care plan reviewed on 01/06/25 reflected she had severe cognitive impairment and had speech deficit and rarely/never understood. Interventions included to monitor for any changes or decline in cognitive status. Record review of Resident #2's Local Intellectual and Developmental Disabilities Authority Habilitation Service Plan dated 01/06/25 reflected the following: .PASRR OT/ST Assessment and Treatment-NEW Observation on 02/21/25 at 10:35 AM of Resident #2 revealed she was in bed and appeared to be non-verbal as she did not respond when she was spoken to. The resident was able to make eye contact only and appeared to require total assistance with all ADLs. Interview on 02/21/25 at 10:42 AM with the PASRR Representative revealed they had a meeting on 01/06/25 with the facility and it was agreed that Resident #2 would be assessed for Occupational and Speech Therapy. The PASRR Representative said they met again on 02/14/25 with the facility staff and realized Resident #2 was not yet receiving the therapy services they had agreed upon. (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/21/25 at 3:06 PM with the Director of Rehab revealed she had not been involved in the PASRR meeting held on 01/06/25 so she was not aware Resident #2 required an occupational and speech therapy assessment. Another meeting was held on 02/14/25 where she did participate, and that was when the Director of Rehab said she had been made aware of the required therapy services. The PASRR Representative decided to drop speech therapy and only wanted the resident assessed for occupational therapy. After the meeting on 02/14/25 the required paperwork was completed and submitted, and Resident #2 was assessed for occupational therapy on 02/16/25. Record review of Resident #2's Occupational Therapy OT Evaluation and Plan of Treatment dated 02/16/25 reflected the resident had been evaluated for occupational therapy. Interview on 02/21/25 at 4:43 PM with the Administrator revealed the previous MDS Nurse was responsible for the PASRR meetings. The Administrator said he was not aware Resident #2 had been approved for new services through PASRR and that the required paperwork had not been submitted. Attempts to contact the previous MDS Nurse on 02/21/25 were unsuccessful. In an interview on 02/21/25 at 5:30 PM with the Administrator revealed the facility did not have a PASRR policy that covered PASRR positive policy, and procedures and they just followed the manual.

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(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 - Immediate jeopardy to resident health or safety 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** 32227 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #1) reviewed for accidents. The facility failed to keep a disinfectant cleaner containing four types of ammonium chloride out of Resident #1's reach to prevent the resident from drinking it. The resident was sent to the hospital after his lips began to swell and turn red. Resident #1 was diagnosed with acid burns to his oral mucosa (the mucous membrane that lines the inside of the mouth, including the cheeks, lips, floor of the mouth, and tongue) and had to be intubated for acute respiratory failure. The noncompliance was identified as past noncompliance. The Immediate Jeopardy began on 01/12/25 and ended on 01/13/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for serious injury or harm, decline in health, and decreased quality of life. Findings included: Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included progressive neurological condition, high blood pressure, diabetes, and Alzheimer's disease. The MDS reflected a BIMS was not conducted on the resident and his cognition was moderately impaired with inattention and disorganized thinking. The MDS further reflected Resident #1 wandered daily. Record review of Resident #1's care plan reviewed on 01/09/25 reflected the resident had cognitive deficit related to dementia and wandered in the evenings. Interventions included to assess for unmet needs such as pain, hunger, thirst, toileting, and to assist with finding location of room and items. Record review of the facility's Provider Investigation Report dated 01/20/25 reflected the following: .On 01.12.25, during routine rounding, [CNA A] observed [Resident #1] with emesis in his bed. As she approached, she noticed a bottle of cleaning spray in his hand. [CNA A] took the bottle of cleaning spray from Resident #1 and placed it on his bedside and then called [LVN B] into the room for assistance. When [LVN B] entered Resident #1's room, [CNA A] had begun to clean [Resident #1], as well as his bedding [Resident #1 was assessed on suspicion of ingestion of a cleaning spray the decision was made to send [Resident #1] to the ER as precaution. When EMT arrived, [Resident #1's] lips had become swollen and were dark pink Record review of Resident #1's progress noted dated 01/12/25 at 9:01 PM documented by [LVN B] reflected the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This nurse was notified by CNA at 6:25 pm, that the resident is vomiting in his bedroom. Upon entering the room, and assessing resident, this nurse, noticed a bottle of cleaning supply sitting on the bed side table. When asked the CNA what the disinfectant was doing in resident room, CNA replied it was there when she entered the room to clean resident. When patient was asked if he drank the bottle of disinfectant, he denied it also denied vomiting. [Physician] notified of the situation via telehealth and stated to give the patient milk and water and monitor if lips had a coral pink tint Poison control called and stated to monitor for GI bleeding Vomit color was clear, no blood noted. Pt sent to [Hospital] Upon the EMT arrival the patients lips were swollen and were dark pink Record review of Resident #1's vital signs recorded following the incident on 01/12/25 reflected: blood pressure was 147/81; pulse 89; respirations 18; temperature 97.8, and oxygen saturation on room air was 96%. Record review of the disinfectant Safety Data Sheet reflected the following: .Product name: RoomSense 200 Disinfectant Cleaner . .Recommended Use: Neutral Disinfectant Cleaner . .2. Hazards Identification Hazard Statements Harmful if swallowed Harmful in contact with skin Causes severe skin burns and eye damage . .3. Composition/Information on Ingredients Hazardous Ingredients Alkyl dimethyl ammonium chloride Octyldecyl dimethyl ammonium chloride Dioctyl dimethyl ammonium chloride Didecyl dimethyl ammonium chloride . .Toxicology Information Ingestion: May cause burns to mouth, throat, and stomach Record review of Resident #1's hospital records dated 01/12/25 reflected the following: .Assessment: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Principal Problem: Drug ingestion, accidental or unintentional, initial encounter. Active Problems: Acute respiratory failure . .Plan: Acute respiratory failure/airway edema/aspiration -d/t ingestion of cleaner, unknow amount -facial, lip, and tongue swelling . .Summary [AGE] year old Patient with dementia, memory care resident who presents with [sic]ccidental ingestion of cleaning liquid which caused acid burn to his oral mucosa with significant swelling of the face Patient got intubated and extubated and transferred out of ICU Interview on 02/21/25 at 10:54 AM with CNA A revealed she entered Resident #1's room, 01/12/25, and noticed the resident had a spray bottle of cleaning solution and noticed he was putting it on his bedside table. Resident #1 was noticed to be spitting on the floor, but she had been told that was a normal behavior for the resident. CNA A asked the resident if he had drank the cleaning solution and the resident said no but the CNA did know if Resident #1 understood what she was asking him. CNA A said she immediately stepped into the hall and called for the nurse, and she took over from there, but the CNA noticed the resident's face was turning red. CNA A further reflected Resident #1 was confused at times and would wander through the facility but normally stayed to himself. Interview on 02/21/25 at 11:08 AM with LVN B revealed she was called into Resident #1's room during the incident on 01/12/25, by CNA A, who said the resident was vomiting but when she entered the room the CNA had cleaned the resident up. LVN B saw the disinfectant spray bottle on the resident's bedside table and the cap was loosely on the bottle. LVN B asked Resident #1 if he had drank the disinfectant to which the resident responded he had not. The physician was contacted, and they were ordered to monitor the resident after they had called poison control who told them to monitor for any changes. After about 45 minutes of monitoring Resident #1, they noticed the resident's lips began to swell, and the sides of his lips had turned red, so he was sent to the hospital for further evaluation. LVN B described Resident #1 as one who wandered with his walker and was normally looking for something to eat or drink. The LVN said he would go into the dining room or the nurse's station looking for snacks, but she had never seen the resident pick up something that was not food related. LVN B further stated the nursing staff did not have access to the housekeeping cleaning products as they were usually kept on their carts or locked in their closets. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/21/25 at 11:38 AM with Housekeeper C revealed she had cleaned Resident #1's room the day of the incident, 01/12/25, around 11:00 AM. She stated when she was done, she recalled putting the disinfectant spray back in her cart. Housekeeper C said that disinfectant was used daily to clean all room surfaces. She further stated all cleaning supplies were kept on their carts or locked in the closets. Housekeeper C stated Resident #1 would hoard items in his room like flower vases and napkins stating the items were his. Multiple attempts to contact the Weekend Supervisor, who worked the day of Resident #1's incident on 02/21/25, were unsuccessful. Interview on 02/21/25 at 11:47 AM with LVN D revealed he worked with Resident #1 and the resident would come out of his room with a walker and eat his meals in the dining room. LVN D said the resident was confused and would wander looking for and hoarding food but said he was easily redirected. Interview on 02/21/25 at 1:05 PM with Resident #1's family revealed the resident had indeed drank the cleaning solution because he had suffered chemical burn to his mouth, lips, and throat and had to be intubated when he was transferred to the hospital. The resident's family further stated the resident was at the hospital for a couple of weeks before he was transferred to another nursing home. Interview on 02/21/25 at 1:05 PM the Housekeeping Supervisor stated their policy was that all chemicals be stored at the bottom of the housekeeping cart where they could be locked while they cleaned the rooms. He said he was told about Resident #1's incident and looked at the schedule and noticed Housekeeper C had been assigned to the resident's room. When she was questioned, the Housekeeper said she indeed had cleaned the resident's room but had taken the disinfectant spray out of the room when she was done. The day after the incident (01/12/25), the Housekeeping Supervisor said he did an audit of all the housekeeping carts to see if the disinfectant bottle was missing from one of the carts and they were all accounted for. After the incident, the Housekeeping Supervisor also said they had changed all the lock and key doorknobs to the janitor closets and replaced them with keypad code locks that automatically lock when the door shuts. He also said he checked the closet doors every afternoon to ensure they were locked, and all housekeeping carts were audited daily to ensure all chemicals were properly stored and accounted for. Interview on 02/21/25 at 2:00 PM with the ADON revealed Resident #1 had dementia and ambulated with a walker. The resident would hoard napkins and saltshakers in his room. The ADON said she was told Resident #1 had drank some cleaning solution and had to be sent to the hospital for further evaluation. She further stated they were not able to determine how the resident got the disinfectant spray and thought he might have taken it from a housekeeper's cart . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/21/25 at 2:53 PM with the DON revealed Resident #1 was alert and oriented to himself and would wander into other resident rooms but was easily redirected. The DON said he was told staff had found Resident #1 in his room with a bottle of disinfectant next to him and the staff were unsure if the resident had ingested the chemical. The doctor and poison control were immediately contacted, and they were told to monitor the resident for any changes. After a while staff noticed Resident #1's lips were turning blue, and he began to cough, the resident was sent to the hospital with the bottle of disinfectant spray, so the hospital staff knew what he had possibly ingested. The DON said Resident #1 mostly wandered looking for and picking up food and that was the first time the resident had been seen with anything that was not a food item. After the incident they conducted a widespread in-service to ensure all staff knew not to keep any type of harmful chemicals within the resident's reach. All staff were reminded to keep any chemicals locked away in the closets. All the housekeepers were re-educated to ensure their carts were always pushed against the walls, so no one had access to the cart doors. All janitor closets' lock and key were changed to a keypad code that only housekeeping had access to. The Weekend Supervisor did a walk-through on the day of the incident to ensure there were no harmful chemicals in the resident rooms and he did another walk-through the day after the incident. Interview on 02/21/25 at 2:18 PM with the Administrator revealed after Resident #1's incident, the Weekend Supervisor ensured there were no other harmful substances in the resident rooms. The Administrator stated cart audits were conducted after the incident (01/13/25) because the staff did not have access to the janitor closets at the time of the incidents to try and find out where the resident had obtained the disinfectant spray from and there were no issues as all the carts were appropriately stocked. He stated all staff were in-serviced to ensure there were no harmful chemicals left out within resident's reach. Record review of the facility's Resident Room Cleaning policy, effective November 2021, reflected the following: Purpose To provide a clean, attractive, and safe environment for residents, visitors, and staff. D. Leave your cleaning cart in the hallway, in sight. If you cannot see your cart, lock the cart. .17. .C. Ensure there are no housekeeping items left in the resident room. A Past Non-Compliance Immediate Jeopardy was identified on 02/21/25. The Administrator was notified of the Past Non-Compliance Immediate Jeopardy on 02/21/25 at 4:44 PM. The IJ template was provided to the facility on [DATE] at 4:59 PM. Observation on 02/21/25 starting at 10:00 AM revealed there were 4 janitor closets, and each door was locked and the there was a code keypad in place. Observation on 02/21/25 from 9:42 AM to 11:59 AM revealed there were no hazardous chemicals in resident rooms. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 02/21/25 at 9:42 AM, 10:10 AM, 10:21 AM, and 1:51 PM revealed the housekeeping carts were locked and there were no chemicals within resident's reach when the housekeepers were cleaning the rooms. Record review of the cart audit dated 01/13/25 reflected all the cart cleaning supplies were accounted for and there were none missing for the 4 cleaning carts. Record review of the resident room audits dated 01/13/25 reflected all residents' rooms were checked to ensure that no hazardous chemicals were present in their rooms. Record review of the daily cleaning cart sign-off sheets reflected each housekeeping cart was being checked by the Housekeeping Supervisor to ensure all cleaning supplies were accounted for in each cart and to ensure the janitor closets were locked from 01/13/25 to 02/21/25. Record review of Housekeeper C's education/training record dated 01/13/25 reflected she had received a 1:1 in-service on securing chemicals and abuse and neglect. Record review of Disinfectant In-service dated 01/13/25 reflected all housekeepers, floor techs, and laundry aides were re-educated to ensure there were no housekeeping items left in the resident rooms after cleaning them or within their reach. Record review of a training in-service titled Don't leave cleaning supplies out. Put away after use. dated 02/21/25 reflected 56 staff has been in-serviced. Interview on 02/21/25 from 9:42 AM to 5:59 PM with CNA A, LVN B, Housekeeper C, LVN D, ADON, Housekeeping Supervisor, CNA E, LVN F, Housekeeper G, CNA H, RN I, RN J, MA K, CNA L, CNA M, CNA N, CNA O, MA P, and LVN Q revealed they were to check the resident rooms for hazardous chemicals when and if they enter. They all stated they were to ensure there were no hazardous chemicals in the resident rooms or within their reach. They were add educated to ensure they called poison control if they suspected a resident had ingested a hazardous chemical.