

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/02/2026
NAME OF PROVIDER OR SUPPLIER The Villages on MacArthur		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure resident rooms were adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for 2 of 10 residents (Residents #1 and #2) reviewed for resident call light system. 1. The facility failed to ensure Resident #1 had a call light. 2. The facility failed to ensure Resident #2's call light was placed within reach. These failures could place residents at risk of injuries and unmet needs. Findings included: 1. 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 end stage renal disease (where the kidneys fail to function adequately), hemiplegia (paralysis of one side of the body), and aphasia (a language disorder that impairs the ability to speak, understand, read, and write). Resident #1 had a BIMS score of 12 which indicated his cognition was moderately impaired. The MDS further reflected the resident used a manual wheelchair for mobility and he required partial to moderate assistance with ADLs. Observation and interview on 01/02/26 at 9:52 AM of Resident #1 revealed he was in his room sitting in his wheelchair, and there was no cord attached to the call light system in his room. The resident said he was able to do a lot of things on his own, despite his right-side paralysis, and because he did not have a call light cord, he would yell out at staff if he needed something. Resident #1 stated he never said anything to the staff about his call light cord because he thought they already knew but would like to have access to his call light to alert staff if he needed something. Interview on 01/02/26 at 9:54 AM with CNA A revealed she had only been working with Resident #1 for about a month. The CNA said she did not realize the resident did not have a call light cord in his room, and Resident #1 usually yelled out if he needed something. Interview on 01/02/26 at 1:41 PM with LVN B revealed she was not aware Resident #1 did not have a call light cord in his room. The LVN said the resident usually went to the nurses' station when he needed something. LVN B said it was important for resident to have access to a call light in case of an emergency or they needed something. 2. Review of Resident #2's face sheet printed on 01/02/26 reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included encephalopathy (disease in which the functioning of the brain is affected by some agent or condition), sepsis (serious condition resulting from the presence of harmful microorganisms in the blood or other tissue), urinary tract infection, and weakness. Review of Resident #2's baseline care plan dated 12/30/26 reflected the resident was not cognitively impaired, had impaired functional abilities, and required assistance with ADL care and mobility. Observation and interview on 01/02/26 at 12:59 PM with Resident #2 revealed she was in her room sitting in her wheelchair to the left of her bed. There was a blue call light cord tied to the bed repositioning bar on the right side of the bed. Resident #2 said she could not reach her call light cord that was tied to the bed and if she needed something she would wait until staff went in to check on her to tell them what she needed. Resident #2 further stated she would like to have access to her call light at all times in case she needed to use it to call staff. Interview on 01/02/26 at 1:30 PM with CNA A revealed he had noticed that call light cords, that were tied to resident's bed, did not reach the resident if they were sitting in their wheelchairs. The CNA said he thought it was a problem if a resident could not reach the call light in case they needed something, but he had not yet told anyone to fix or untie the call light cords. Interview on 01/02/26 at 3:26 PM with the ADON revealed she was not aware Resident #1 did not have a call light or that Resident #2 could not reach hers. The ADON said the call lights needed to be within resident reach because that was their method of communication in case they needed anything. Interview on 01/02/26 at 4:18 PM with the Administrator revealed he was not aware Resident #1 did not have a call light cord or that Resident #2 did not have hers within reach. The Administrator said his expectation was that all residents had access to their call light in case there was an emergency or need something important. Review of the facility's policy titled Answering the Call Light dated September 2003 reflected the following: Purpose The purpose of this procedure is to respond to the resident's request and needs. 4. Be sure that the call light is plugged in at all times. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.</p>		