| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676358 | A. Building<br>B. Wing | 07/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Villages on MacArthur | 3443 N MacArthur Blvd<br>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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>(continued on next page) |

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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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to accommodate the needs and preferences for one (Resident #23) of five residents reviewed for accommodation of needs, in that: The facility failed to provide a working communication system, that was easily within reach, that would allow Resident #23 the ability to safely call staff for assistance. This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they needed support for daily living. The findings included: Review of Resident #23's Record of Admission, dated 07/02/25, reflected she was a [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #23's Quarterly MDS Assessment, dated 05/16/25, reflected she had a BIMS score of 12, indicating moderate cognitive impairment. Her active diagnoses included heart failure (occurs when the heart muscle did not pump blood as well as it should), diabetes mellitus (a disorder characterized by high blood sugar levels due to the body's inability to produce or respond effectively to insulin), and quadriplegia (characterized by paralysis of all four limbs and the torso). Resident #23's functional abilities revealed she was dependent which meant the helper did all the effort for the resident in regard to dressing, eating, and personal hygiene. Review of Resident #23's care plan, dated 07/02/25, reflected the following: Care Area/Problem: *Fall Risk.Interventions: Keep call light and most frequently used personal items within reach. Care Area/Problem: *At risk for problems with Elimination.Interventions: Keep call light within reach, and remind resident to call for assistance . Observation and interview on 07/01/25 at 10:48 AM with Resident #23 revealed she was laying in her bed and had her bedside table in front of her which had a silver call bell in front of her. Resident #23 was noted to have contractures to both of her hands and had minimal use of her arms. Resident #23 said the call light system at the facility had been out for 4 days now and she was given a call bell to use but she could not use the one that was given to her. Resident #23 said due to her contractures and the way her arms could not raise high enough to use the bell she had no way to call out for help. Resident #23 said her only option was to yell out, but it was unreliable if that would work because she was not sure if staff would be able to hear her yelling. Resident #23 said she normally used a push pad when the call light system for the facility was working. Interview on 07/02/25 at 10:41 AM with LVN A revealed there was a thunderstorm a few days ago which caused the electricity to go out and due to that the call light system failed. LVN A said staff brought out bells to give to residents and began rounding on them every 30 minutes. LVN A said staff had been in-serviced to listen for any bells ringing. LVN A said Resident #23 was an exceptional case because of her contractures, she normally used a push pad call light that was flat and stayed on her chest that she could easily use. LVN A said she was given a dinging bell that was on her bedside table while the call light system was out. LVN A said he knew Resident #23 could not reach or use the one she was provided temporarily while the call light system was out. LVN A said instead, he was checking on Resident #23 every 30 minutes. LVN A did not provide an answer when asked what could happen to Resident #23 in between the every 30 minute checks. LVN A said he was not sure why Resident #23 was given a temporary call bell that she could not use. Interview on 07/02/25 at 10:50 AM with ADON B revealed she was on vacation last week and was not sure what happened to the call light system, but heard that it went out due to bad weather. ADON B said she noticed staff had put out temporary call bells for residents to use. ADON B said if a resident could not use the temporary call bell given to them, they were checked on by staff every 15 to 30 minutes. ADON B said she was not sure about any other temporary call bells offered to Resident #23, but she should have been given one that she could use. Interview on 07/03/25 at 3:34 PM with the DON revealed the facility's call light system went out on 06/25/25 in the evening time. The DON said a thunderclap was heard and then the system stopped working. The DON said Resident #23 was given a bell originally that she could not use, so staff were checking on her frequently. The DON said as of today (07/03/25), Resident #23 was given a different call bell that was modified so that she could use it with ease. The DON said Resident #23 required a call bell that was flat so she could use it, and the facility did not have one at the time the call light system stopped working. The DON said he knew Resident #23 could not press or lift her arm high enough to press the original call bell that she was given. The DON said all residents should have a call device that they could use if they were cognitively able to use one. The DON said Resident #23 was alert and oriented and knew how and when to use a call light or bell. Interview on 07/03/25 at 6:30 PM with the Administrator revealed the facility did not have a policy addressing call lights |

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|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for one of six residents (Resident #87) reviewed for abuse. The facility failed to ensure Resident #87 had the right to be free from abuse when Resident #3 physically assaulted her on 03/03/25. The noncompliance was identified as PNC. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for abuse. Findings include: Review of Resident #87's Face Sheet, dated 07/02/25, reflected she was an [AGE] year-old female who was admitted to the facility on [DATE]. Review of Resident #87's Quarterly MDS Assessment, dated 05/29/25, reflected she had a BIMS score of 10, which indicated moderate cognitive impairment. Her active diagnoses included stroke (occurs when a blood vessel in the brain leaks or bursts and causes bleeding in the brain), hypertension (high blood pressure), and diabetes (a chronic, metabolic disease characterized by elevated levels of blood glucose). Review of Resident #87's Care Plan, dated 07/02/25, reflected nothing related to the incident that occurred on 03/03/25. Review of Resident #87's Nurses Notes reflected the following: -LVN I on 03/06/25 at 9:51 AM wrote the following for 03/03/25 Around 0708 , [sic] this nurse heard resident's loud voice coming from the dining room and reached immediately. The resident was standing next to the dining kitchen looking on the breakfast tickets and other resident was on the corner of the dining room in her wheelchair. No noise anymore. This nurse asked the resident, Is [sic] she okay and tried to comfort her. [sic] Resident stated, 'she is not okay. [sic] Other resident had not let me to pick out my ticket and she slapped me on my right face . [sic] Now, i [sic] have a small scratch with burning sensation on it.' Head to Toe assessment was done. Pt. was alert and oriented x3. move [sic] all extremities freely. No bleeding on the face. Light redness on the right cheek. A small scratch close to upper lip. Cleaned the face and pat dried. Applied skin protectant ointment. Refused to take the pain medication. Vital 124/68 pulse 64. o2 [sic] sat 97% resp 18. This incident was witnessed by dietary department Staff [sic] member who was in the kitchen. Notified Abuse coordinator [sic] immediately. Left voice mail for [Resident #87's Family Member] to call back to the facility. Notified Doctor NP and DON. Neuro starts [sic]. Will continue to monitor. Resident ate in the dining room [ROOM NUMBER]% with meal. Around 9 am [sic] resident was walking in the hallway. No complain of pain. No redness and scratched [sic] mark on the right face noted. Calm. Around 10:25 am [sic], resident took her PRN Pain [sic] medication. No Redness [sic] on the right face. A&OX3. Calm. Resident has the order of UA [sic]. COMPLETE URINALYSIS- REFLEX TO URINE CULTURE One [sic] time only per NP. Resident is not ready for urine specimen this time. Notified on coming [sic] nurse to follow up with it. Review of Resident #87's Social Services Note reflected the following:-the Previous SW wrote the following on 03/03/25 at 10:17 AM: Patient was slapped on the cheek by another resident. SW did a wellness check on resident. Nurse gave patient topical for her cheek put patient [sic] declines oral pain pill at this time. She states that she does not know why the other resident slapped her but that she would like a referral to another facility.-the Previous SW wrote the following on 03/05/25 at 1:17 PM: SW assisted patient with making TULIP HHSC suspected elder abuse report.-the Previous SW wrote the following on 03/06/25 at 10:26 AM: SW followed up with patient again today. She states she has mouth pain from the incident but declines medication for the pain. She states she does not feel comfortable going into the main dining room where the incident occurred. SW offered to escort patient to eat in the alternative dining room or in her room. Patient declined. Observation and interview on 07/02/25 at 2:15 PM with Resident #87 revealed she did not have any visible marks to her cheeks or face. Resident #87 said she was slapped by another resident and had pain in her mouth because of what happened. Resident #87 said sometimes it still hurt her mouth now because of how hard she was hit. Resident #87 said it hurt her too much to think about what happened to her when she was slapped and that no one should ever hit seniors like that. Resident #87 said she wanted that person in jail, but she was not sure what happened after the police came to ask her questions because she did not receive a follow-up. Review of Resident #3's Face Sheet, dated 07/02/25, reflected she was a [AGE] year-old female who was originally admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #3's Quarterly MDS Assessment, dated 04/04/25, reflected she had a BIMS score of 14, indicating no cognitive impairment. Her active diagnoses included cerebral palsy (a brain disorder that appears in infancy or early childhood that permanently affects body movement and muscle coordination), anxiety disorder (a group of mental disorders characterized by intense |

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|---|---|
| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure completion of a discharge summary including a recapitulation of the resident's stay, and final status at discharge for one resident (Resident #113) of five residents reviewed for discharge summary. The facility failed to complete a discharge summary for Resident #113. This failure could place residents at risk of not having complete records after permanent discharge from the facility and disruption in the continuity of care. Findings included: Review of Resident #113's Face Sheet, dated 07/02/25, reflected she was a [AGE] year-old female who was originally admitted to the facility on [DATE], readmitted on [DATE], and discharged on 04/08/25. Her diagnoses included bipolar disorder (a mental health condition characterized by extreme mood swings that include emotional highs and lows), schizophrenia (a chronic mental health condition that affects how individuals think, fell, and behave), and depression (a mood disorder that causes persistent feelings of sadness and loss of interest). Review of Resident #113's Nurses Notes reflected the following: - On 04/08/25 at 3:40 PM, RN C wrote: Resident leaving AMA , [sic] V/S normal, alert and oriented*4 [sic], All [sic] medication and belonging [sic] given to resident, resident left facility with uber driver. Review of Resident #113's electronic health record revealed there was not an MDS assessment completed for her. Review of Resident #113's undated Interdisciplinary Discharge Summary reflected it was not completed. The following areas of the form were not filled out or completely filled out: Recapitulation of Resident's Stay, Physician Signature, Social Services Summary of Stay, Activity Summary During Stay, and Therapy Services Summary of Stay. Interview on 07/03/25 at 10:20 AM with the SW revealed he had only been at the facility for two weeks. The SW said he had completed a few discharge summaries for residents and completed his portion of the form for those. The SW said the other departments fill out the rest of the portions for their respective disciplines. The SW said he was only responsible for filling out his portion of the form. Interview on 07/03/25 at 10:35 AM with Medical Records revealed she was responsible for making sure that the discharge summary was completed by each department on the form. Medical Records said normally she checked the discharge summary and if she saw it was not completed by certain departments, she would let them know to make sure to fill it out. Medical Records said she was not sure why the other departments had not filled out Resident #113's discharge summary and she at the time did not catch that it was not completed. Medical Records said normally she checked each discharge summary for completion after a resident discharged . Interview on 07/03/25 at 3:29 PM with the DON revealed Resident #113's discharge summary should have been completed by each department listed on the form. The DON said the discharge summary for a discharged resident should have been completed as soon as possible but he was not sure of a more specific timeline. The DON said each department would have been responsible for their respective section and Medical Records checked the form to ensure that the entire form was completed. The DON said the purpose of a discharge summary form was to give information on what care the resident received at the facility. The DON said if the form was not completed the resident might miss something that should have been follow-up on after they left. The DON said all staff had been trained to fill out their own sections on the discharge summary forms. A discharge summary policy was requested but not provided prior to exit. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate assessments with the PASRR program for 1 of 5 residents (Resident #55) reviewed for PASRR assessments.The facility did not refer Resident #55 to the appropriate state-designated mental health authority for review when she received a new diagnosis of schizophrenia on 10/17/24.This failure could place residents at risk of not being evaluated and receive needed PASRR services.Record review of Resident #55's quarterly MDS Assessment, dated 03/26/25, reflected the Resident #55 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #55 had an active diagnosis of depression disorder (a common mental health condition characterized by persistent sadness and a loss of interest or pleasure in activities), anxiety disorder (a natural human emotion characterized by feelings of worry, nervousness, or unease, typically about an event with an uncertain outcome), schizophrenia (a chronic mental health disorder that affects how a person thinks, feels, and behaves) and the resident had severe cognitive impairment with a BIMS score of 03.Record review of Resident #55's PASRR Level 1 Screening, dated 07/10/24, reflected she did not have a mental illness. PASRR Level 1 screening did not indicate Resident #55 had primary diagnosis of dementia.Interview on 07/03/25 at 04:04PM, the DON stated if a new diagnosis was given to a resident a new PASRR evaluation should have been completed. DON stated when Resident #55 was diagnosed with a new diagnosis on 10/17/24, the MDS nurse was on transition to another facility and was supposed to follow up, but she did not, and she did not let him or the regional MDS nurse know. He stated the MDS nurses were monitored by the Regional Corporate Nurse, and she should be asked about any questions regarding Resident #55's PASRR. Interview on 07/03/25 at 04:42 PM, Regional MDS nurse stated Resident #55 had a negative PASRR Level 1. She stated Resident #55 was negative and she does not understand how the doctor came schizophrenia diagnosis. The Regional MDS Nurse said she reviewed Resident #55's medical chart after she was notified on 07/02/25 by DON and found out Resident #55 had a diagnosis of schizophrenia which she was diagnosed on [DATE] and no new PASRR I screening was done. She stated she was not aware screening was not done, and she will be notifying the authorities. She stated failure to perform screening and involving the authorities, Resident #55 failed to get required assessments and could lead to her not receiving services that could have benefited her. Record review and interview with the Administrator regarding the facility's PASRR policy on 07/03/25 at 05:30PM, she stated the facility had no policy, but they used the State guidelines. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for one (Resident #33) of 19 residents reviewed for care plans. The facility failed to develop a care plan to address Resident #33's self-transfer to the toilet and stay there for long periods of time, sometimes falling asleep, multiple times a day. This failure could place residents at risk of receiving inadequate interventions not individualized to their care needs. Findings included: Review of Resident #33's MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE] and discharged [DATE]. [VT1] Her diagnoses included anxiety disorder, apraxia (a neurological disorder that affects a person's ability to perform learned purposeful movements even though they have the desire and physical ability to do so), dysphagia (difficulty swallowing foods or liquids), and aphasia (a language disorder that affects the ability to communicate) all following a stroke. The MDS further reflected she has long and short -term memory impairment and required supervision or touching assistance for transfers. Review of Resident #33's care plan dated 05/02/24 reflected the resident had impaired physical mobility. Interventions included to provide the appropriate level of assistance to promote safety of resident. The care plan did not reflect the resident's self-transfer to the toilet without staff assistance and staying on the toilet for long periods of time. Interview on 07/03/25 at 9:43 AM with Resident #33's Family revealed Resident #33 had stroke but was still able to self-transfer to the toilet if she positioned herself just right. Through out the years the resident had a decline and was weaker and the Family did not want her transferring herself anymore. The Family said Resident #33 was transferring herself to the bathroom and would fall asleep on the toilet and she had expressed her concerns to ADON B and the DON during care plan meeting, but they had told the Family the staff had to let the resident have as much independence as she could. Interview on 07/03/25 at 10:17 AM with LVN J revealed Resident #33 had been a resident at the facility for a long time and she appeared to have declined within the last year, but the resident was still able to transfer to the toilet from her wheelchair. The resident was encouraged to call for assistance but Resident #33 preferred to do it on her own and at times would want to sit on the toilet for long periods of time, even thought she was not using the bathroom. All the staff were instructed to check on Resident #33 more frequently to try to prevent any falls or to redirect the resident if she would fall asleep on the toilet. LVN J further stated staff were also directed to try and keep the resident in the common areas but Resident #33 would self-propel her wheelchair back to her room. Interview on 07/03/25 at 10:45 AM with CNA K revealed Resident #33 was almost independent with most ADLs and if staff tried to help, the resident would become upset. Resident #33 would transfer herself to toilet and at times during their rounds, staff would find the resident asleep on the toilet and would have to assist her back into her chair or to bed. CNA K said Resident #33 liked to sit on the toilet for long periods of time and would become upset if they tried to assist her back into her wheelchair during their rounds of the resident. CNA K further stated Resident #33 was encouraged to ask for assistance and they tried to keep her in common areas and all staff would make frequent rounds on the resident. Interview on 07/03/25 at 11:39 AM with CNA L revealed Resident #33 was independent and preferred to do most of her ADLs on her own. She said the resident was able to take herself to the bathroom and transfer to the toilet from her wheelchair. CNA L said staff were instructed to make frequent checks on Resident #33 because she would fall asleep on the toilet, and they would try and assist the resident back to her wheelchair or to bed. Interview on 07/03/25 at 12:37 PM with ADON B revealed Resident #33 was independent enough to take herself to the bathroom even though they encouraged the resident to call for assistance. She said Resident #33 would stay on the toilet for long periods of time and at times would fall asleep. ADON B said the family had concerns about the resident falling asleep on the toilet and they were told staff were making frequent checks on the resident to try to redirect and prevent falls. Interview on 07/03/25 at 4:11 PM with the DON revealed Resident #33 used a wheelchair for mobility and she transferred herself to the bathroom even though she was encouraged to call for assistance. The DON said Resident #33 liked to sit on the toilet for long periods of time and would fall asleep sometimes and if they tried to redirect the resident, she would become upset. The staff were instructed to make frequent checks on the resident if she was in her room to assist as much as they could |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>(continued on next page) |

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|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 5 residents (Resident #8) reviewed for ADL care. The facility failed to provide Resident #8 assistance with timely incontinence care for at least 5 hours. Resident #8 was observed to be soaked and soiled through to her wheelchair padding. This failure could place the residents at risk for decreased feelings of self-worth, skin breakdown, and infection. Findings included: Record review of Resident #8's face sheet, dated 07/03/25, revealed Resident #8 was admitted to the facility on [DATE]. Record review of Resident #8's Comprehensive MDS assessment, dated 05/25/25, revealed Resident #8 had cognition intact with a BIMS score of 15. Resident #8 was noted to be dependent on staff for toileting, with substantial/max assistance with sit to stand, chair to bed transfer, and toilet transfer. Resident #8 was always incontinent of urinary and bowel. Active diagnoses included Stroke, Heart Failure, High Blood Pressure, High Blood Sugar, Hemiplegia or Hemiparesis (paralysis that affects only one side of the body), anxiety disorder and Chronic Obstructive Pulmonary Disease. Review of Resident #8's care plan, dated 07/03/25, revealed Resident #8 had Impaired Physical Mobility related to history of Paraplegia evidenced by general weakness. Goal: Maintain or improve physical function in Bed Mobility, Transfer, Ambulation, Locomotion, and Range of Motion. Intervention: Provide appropriate level of assistance to promote safety of resident. Resident #8 had Self Care Deficit related to limited joint mobility interfered with hygiene, and causing resident to have higher risk of skin breakdown. Goal: Maintain or improve self-care area of dress, grooming, hygiene, and bathing. Intervention: provide assistance with self-care as needed. Resident #8 at risk for problems with elimination evidenced by usual bowel pattern: daily. Goal: Resident's elimination status will be maintained or improved. Intervention: Assist to toilet as needed. Uses a brief. Resident #8 at risk of skin breakdown evidenced by Incontinent of bowel, always incontinent to bladder, confined to bed and chair most of the time, bed mobility and transfers: extensive. Goal: remain clean and intact skin. Interventions: apply protective or barrier lotion after incontinence. Keep skin clean, dry, and free of irritants. Observation on 07/01/25 at 12:11 PM revealed CNA M exiting Resident #8's room with soaked and soiled bedding and briefs. CNA M returned to provide resident with clean bedding. Observation on 07/01/25 at 2:56 PM revealed Resident #8 in her room, ringing her bell to alert staff she needed assistance. Interview on 07/01/25 at 3:02 PM with Resident #8 revealed her saying I will not say I am good because no one comes to help me. Been here 2 months and it has been like this the whole time. I am paralyzed from my stroke on the right side and need help. I need to be changed right now so I can go therapy, and it has been a couple of hours since I was last changed. I think the last time I was changed was around 10:00 am before my therapy. My head nurse came in and I told her I need changed & they still have not come back in (over an hour ago). They do not check on me unless they are giving medications. I do have painful areas on butt from not being changed and laying/sitting all day. Was put in chair around 10 am and left there. This is what happens every day. Interview on 07/01/25 at 3:13 with RN D revealed she did stop to speak with Resident #8 upon her shift shortly after 2:00 PM. RN D stated Resident #8 did ask to be changed. RN D stated she alerted CNA M at the time and would follow up with him to assist Resident #8 with incontinent care. RN D walked away to speak with CNA M. Observation on 07/01/25 at 3:18 PM of CNA M entered Resident #8's room to inform family members that he needed to assist Resident #8 with a brief change. CNA M then left the room stating that he needed to gather supplies and was waiting on another person to assist with care. Interview and observation on 07/01/25 at 3:21 PM with CNA M revealed him stating I changed Resident #8 this morning around 11:00 AM, before she went to therapy. CNA M and CNA N returned, both washed hands in bathroom and donned appropriate personal protection equipment. Observation on 07/01/25 at 3:27 PM revealed staff removed oxygen from Resident #8 to complete transfer to the bed. There was a strong urine odor immediately in room once Resident #8 was laid down. Resident #8's brief soaked through onto a blanket on wheelchair; stool was present. CNA M used Peri wash to clean resident. Resident #8 presented with redness on her lower buttocks/upper thigh area, more significant to left leg. Redness in between legs/right vaginal crease. CNA M cleaned vaginal area after cleaning feces and cream was applied to buttocks and vaginal crease. Interview on 07/01/25 at 3:58 PM with CNA M revealed Resident #8 was last changed at 11:00 AM, Resident #8 then went to therapy and had lunch. I am responsible to check on residents every 2 hours, however Resident #8 |

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|---|---|---|---|
| | 676358 | A. Building<br>B. Wing | 07/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Villages on MacArthur | 3443 N MacArthur Blvd<br>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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **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 needs respiratory care was provided such care, consistent with professional standards of practice for one of three residents (Residents #8) reviewed for oxygen. 1. The facility failed to ensure Residents #8's orders for oxygen administration were being accurately provided. This failure placed residents who received oxygen therapy at risk for inadequate or inappropriate amounts of oxygen delivery and ineffective treatment. Findings included: Record review of Resident #8's face sheet, dated 07/03/25, revealed Resident #8 was admitted to the facility on [DATE].Record review of Resident #8's Comprehensive MDS assessment, dated 05/25/25, revealed Resident #8 had cognition intact with a BIMS score of 15. Resident #8 was noted to have shortness of breath or trouble breathing when lying flat and required oxygen therapy. Active diagnoses included Stroke, Heart Failure, High Blood Pressure, High Blood Sugar, Hemiplegia or Hemiparesis (paralysis that affects only one side of the body), anxiety disorder and Chronic Obstructive Pulmonary Disease. Review of Resident #8's care plan, dated 07/03/25, revealed Resident #8 with breathing patterns related to diagnosis of Chronic Obstructive Pulmonary Disease [05/18/25: Onset] Evidenced by Oxygen 2 Liter per Minute Inhalation every shift. Goal: Resident will demonstrate an effective respiratory rate, depth, and pattern. Establish a normal/effective respiratory pattern with arterial blood gas within patient's normal range. Interventions included adjust head of bed and body positioning to assist ease of respirations. Administer medications, respiratory treatments, and oxygen as ordered. Monitor lung sounds, pallor, cough, and character of sputum. Monitor respiratory rate, depth, and effort. Notify physician and family of any change of condition. Record review of Resident #8's physician's orders revealed:Oxygen 2 liters per minute by nasal canula continuous Start dated 06/16/25 for Oxygen saturation, oxygen lung shortness of breath. Oxygen Saturation check for oxygen assistance, oxygen saturation, and respiration. Observation and interview on 07/01/25 at 2:57 PM with Resident #8 revealed she was sitting in a wheelchair with use of oxygen at 3 liters per minute. According to Resident #8, I have trouble with my esophagus and sometimes I feel like I'm suffocating, I am supposed to be on 2 liters of oxygen to assist with my breathing. Resident #8 stated staff usually checked it nightly when they come in to administer her bipap machine, no one had ever stated the oxygen level had increased to 3 liters. Observation on 07/03/25 at 12:10 PM of Resident #8 revealed she was at bedside resting with tubing in her nose, and the oxygen level was at 3 liters per minute. Observation and interview on 07/03/25 12:18 PM with LVN F revealed Resident #8 was sitting on the side of the bed with tubing in her nose, the oxygen level was at 3 liters per minute. According to LVN F the resident should be on an oxygen level of 2 liters per minute. LVN F reviewed Resident #8's orders and confirmed she should be on 2 liters per minute and stated Resident #8's oxygen was to be checked daily. LVN F stated he was new to the facility and working with Resident #8, he was not sure who provided an increase in oxygen or when it was increased to 3 liters per minute and stated he would contact the physician for clarification of the order. LVN F stated there should not have been an increase in Resident #8's oxygen level without a physician's order to do so. LVN F stated there was risk involved with having a higher level of oxygen. LVN F stated the nursing staff was responsible to inform the physician prior to making any changes in the order, and to monitor Resident #8's oxygen each shift daily. LVN F stated not following physician orders provided a risk to the resident breathing patterns. Interview with the DON on 07/03/25 at 3:11 PM revealed Resident #8 was on oxygen. The DON stated nursing staff should be checking Resident #8's water, tubing, and level of oxygen flow on each shift daily. According to DON Resident #8 or family members change it therefore staff had to provide education to on not increasing the oxygen level. The DON stated having an increase in oxygen could place the resident's body at risk of becoming used to needing a higher level of oxygen. The DON stated it was the nursing staff's responsibility to check the oxygen level daily and every shift, enter new orders from the physician and document as to why Resident #8's oxygen was increased. Record review of facility's Following Physician Orders policy, last reviewed November 27, 2023, reflected: .The licensed nursing staff will provide residents with medications and treatments as ordered by his/her physician. |

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|---|---|---|---|
| | 676358 | A. Building<br>B. Wing | 07/03/2025 |

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| The Villages on MacArthur | 3443 N MacArthur Blvd<br>Irving, TX 75062 |

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|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident on one of 4 medication carts (500 Halls cart) and 2 of 4 residents (Residents #50 and #63) reviewed for pharmacy services. The facility failed to ensure the 500 Hall nurses' medication cart had accurate narcotic counts for Residents #50 and #63.This failure could place residents at risk for medication errors, drug diversion, and delay in medication administration. Findings included:1.Record review of Resident #50's quarterly MDS Assessment, dated 06/25/25, reflected the Resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #50 had diagnoses which included Unspecified fracture of upper end of left humerus. The Resident's BIMS score was 12 indicating his cognition was moderately impaired. Section J-health conditions revealed she was on pain management. Record review of Resident #50's physician's orders, dated 06/19/25, reflected an order for Resident #50 to receive morphine sulfate 15mgs, 1 tablet by mouth twice daily for pain. 2.Record review of Resident #63's quarterly MDS Assessment, dated 05/06/25, reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #63 had diagnoses which included other neurological conditions (wide range of disorders affecting the brain, spinal cord, and nerves) and hypertension (high blood pressure). The resident's BIMS score was 11 indicating his cognition was moderately impaired. Section J-health conditions reveal she was on pain management. Record review of Resident #63's physician's orders, dated 06/17/25, reflected an order for the resident to receive oxycodone hydrochloride 5mgs, 1 tablet by mouth every six hours at 01:00AM, 07:00AM, 01:00PM, 07:00PM for pain. Observation and record review on 07/02/25 at 11:20 AM of the 500 Hall nurses' medication cart and the Narcotic Administration Record with LVN C revealed Resident #50's Narcotic Administration Record for morphine sulfate 15mgs reflected a total of 10 pills remaining, while the blister pack count was 09 pills. It had last been administered on 07/01/25 at 08:00PM. Resident #63's Narcotic Administration Record for oxycodone 5mg reflected a total of 103 pills remaining, while the blister pack count was 102 pills. It had last been administered on 07/02 01:00AM. Interview with LVN C on 07/02/25 11:39 AM revealed she administered Resident #50's morphine sulfate Oral Tablet 15 mg 1 tablet twice and oxycodone 5 mg I tablet to Resident #63 every 6 hours, at 09:00AM and she had not signed off on the Narcotic Administration Record log. She said she gave the residents the medication, but she forgot to sign off on the Narcotic Administration Record. She stated she knew she was supposed to sign-out on the narcotic count sheet log after popping the pill from the blister and on the Medication Administration Record, but she did not. LVN C stated failure to sign off narcotics could lead to overdose since the person who came after her would not be able to tell when the narcotic was administered and could lead to medication error. She said she had done in-service on medication administration, but she could not recall when.Interview on 07/03/25 02:45 PM with the ADON B revealed her expectation was for staff administering narcotic medications to document the medications when they were given to the resident on the MAR and to sign on the narcotic log. The ADON B said failure to document could lead to overdose and missing pills. She said it was her responsibility to audit the medication carts once a week and she could not tell when she last audited. She said the facility had completed in-services on medication administration and narcotic sign out and she could not recall when.Interview on 07/03/25 04:08 PM with DON revealed his expectation was for staff administering narcotic medications to document the medications when they were given to the resident on the MAR and to sign on the narcotic log. DON said failure to document could lead to overdose and missing pills. He said it was his and the ADON's responsibility to audit the medication carts and perform random checks 2-3 times a week and he could not tell the last time they checked. He said the facility had completed in-services on medication administration and narcotic sign out.Record review of the training records on narcotic administration was requested on 07/03/25 and none were provided. Record review of the facility's Controlled Substances Administration policy, dated 01/23, reflected the following: .4. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability when removing dose from controlled storage. a.Date and time of administrationb. Amount administeredc. Signature of the nurse administering the dose |

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| | 676358 | A. Building<br>B. Wing | 07/03/2025 |

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|---|---|
| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure each resident's drug regimen was free from unnecessary drugs, to include adequate monitoring for four (Residents #1, #33, #45 and #55) of six residents reviewed for unnecessary medications. 1.The facility failed to monitor worsening of depression and behaviors for Resident #1's for the use of Sertraline 50mgs and ramelteon 8 mg tablet (antidepressants medication). 2. The facility did not monitor Resident #33 for side effects of the antidepressant medication, Mirtazapine; the antipsychotic medication, Quetiapine; the antianxiety medication, Trazodone; and the antidepressant medication, Duloxetine. 3.The facility failed to monitor behaviors for Resident 45's for the use of Alprazolam Tablet 0.25 MG for (anti-anxiety), fluoxetine 40mg and Ramelteon 8 mg tablet (antidepressant medications).4.The facility failed to monitor behaviors for Resident #55's for the use of bupropion, mirtazapine (antidepressant medication) and quetiapine (an antipsychotic medication. These failures could place residents at risk of increased behaviors, negative outcomes, and a decline in health. Findings included:1.Record review of Resident #1's quarterly MDS Assessment, dated 03/18/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included depression. The resident BIMS score was 13 indicating his cognition was intact. Section N high risk drug classes indicated he was on an antidepressant.Review of Resident #1's care plan, dated 03/04/25, reflected the following: Focus: Resident #1 on antidepressant evidenced by Sertraline 50mg 1 tablet by mouth per day . Goal: The Resident will be free of any discomfort or adverse side effects. Interventions: Administer medications as ordered. Monitor closely for worsening of depression and/or suicidal behavior or thinking, especially during initiation of therapy and during any change in dosage. Monitor for Interaction/Adverse side effects: Dizziness, nausea, diarrhea, anxiety, nervousness, insomnia, somnolence, weight gain, anorexia, or increased appetite.Record review of Resident #1's Physician's Orders dated 5/14/2025 with a start date of 06/20/25 revealed the following:Sertraline Tablet 50 MG give one tablet by mouth two times a day and Ramelteon 8 mg 1 tablet at bedtime related to depression disorder. The orders did not include any orders to monitor for side-effects related to the use of the Sertraline 50mgs and Ramelteon 8 mg tablet.Record review of Resident #1's June 26, 2025, to July 3, 2025, MAR/TAR revealed he had been receiving the Sertraline 50mgs and Ramelteon 8 mg tablet as ordered each day. The MAR/TAR did not include documented evidence the facility was monitoring for side-effects related to the use of the SertralineReview of Resident #33's Face Sheet, dated 07/03/25, reflected she was a [AGE] year-old female who was admitted to the facility on [DATE].Review of Resident #33's Quarterly MDS Assessment, dated 04/08/25, reflected she had a BIMS score of 11 indicating moderate cognitive impairment. Her active diagnoses included non-Alzheimer's dementia (the loss of memory and other intellectual functions severe enough to cause problems in one's abilities to perform daily tasks), anxiety disorder (a group of mental disorders characterized by intense feelings of anxiety and fear), and bipolar disorder (a mental health condition characterized by extreme mood swings that include emotional highs and lows). At the time of the MDS Assessment, Resident #33 received antipsychotic and antidepressant medications. Review of Resident #33's physician orders reflected the following: -Mirtazapine, 15 MG tablet, 1 tab at bedtime-Quetiapine Fumarate, 50 MG tab, 1 tab every 12 hours-Trazodone, 50 MG Tablet, .5 tablet at bedtime for Insomnia-Duloxetine HCL DR, 20 MG Cap, 1 Cap twice a day Review of Resident #33's Care Plan, dated 07/03/25, reflected the following: Care Area/Problem: Antidepressant.Related To: [Resident #33] has a DX of Bipolar.Evidence By: duloxetine as ordered, trazodone as ordered, mirtazapine.Interventions: Anti-Depressant SE: Dry Mouth Blurred Vision Constipation Urinary Retention of Hypotension Appetite Changes Headache Insomnia Weight Changes.Monitor closely.Care Area/Problem: Psychotropic Drug Use. Related To: [Resident #33] has a diagnosis of Bipolar and Psychotic disorder.Evidence By: quetiapine as ordered.Interventions: Observe for possible side effects every shift.Interview on 07/02/25 at 3:41 PM with LVN C revealed she cared for Resident #33 and knew she received anti-depressant, anti-anxiety, and anti-psychotic medications. LVN C said normally with any of those medications, a resident would also be monitored for any side effects related to them. LVN C said the monitoring orders should have been included in Resident #33's orders but she did not see any and did not recall completing the documentation of monitoring it in the resident's chart. LVN C said she was not sure why there were not any monitoring orders included in the resident's chart. LVN C said she had not noticed the orders missing because they were using |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>(continued on next page) |

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|---|---|
| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure all drugs and biologicals were stored securely for 2 (Resident #314 and Resident #324) of 18 residents observed for medication storage. 1. Resident #314 had a tube of Estradiol cream at her bedside table not locked in a lock box or secured in the medication cart or medication room. 2. Resident #324 had Clotrimazole vaginal antifungal cream on her bedside table not locked in a lock box or secured in the mediation cart or mediation room. This failure could place residents at risk of overmedication or adverse drug reactions.Findings included: 1. Record review of Resident #314's Face Sheet, dated 07/03/25, revealed the resident was a [AGE] year-old female who was admitted on [DATE]. Review of Resident #314's MDS dated [DATE] revealed the resident's cognition was moderately impaired with a BIMS score of 12. Resident #314 had diagnoses that included Stroke, hyperlipidemia (cholesterol and fats in blood), hypertension (high blood pressure), and diabetes mellitus (high blood sugar). Resident #314 required partial/moderate assistance with toileting and occasionally had urinary incontinence. Review of Resident #314's care plan, dated 07/03/25, revealed the resident had use of Antidepressant evidenced by escitalopram 20 mg tablet (Escitalopram Oxalate) 1 tablet by mouth 1 time per day, trazadone 50 mg tablet (Trazodone HCL) 0.5 tablet by mouth at bedtime 14 days as needed for Insomnia. Goal: resident will be free of any discomfort or adverse side effects. Interventions included administer medication as ordered. Monitor closely for worsening of depression and or suicidal behavior or thinking. Monitor dosage, duration, and interaction/adverse side effects. Monitor for risk of falls and report lab results. No mention of Estradiol cream use. Record review of Resident #314's Medication Administration report dated July 2025 revealed physician's order for Estradiol 0.1 MG/1 GM Cream (Estradiol) 1 gram One time daily [Frequency: Weekly on Wednesday, Saturday Time: 08:00 PM] for Hormone treatment Vaginal Use Only. Started 06/17/25-07/02/25 and restarted 07/02/25.0 Observation on interview on 07/01/25 at 10:23 AM revealed Resident #314 with a boxed prescription of cream, used syringe, and used gloves with white cream on the gloves on the nightstand table. According to Resident #314, an unknown staff member (she thought it was a nurse) brought the prescription in the room for her to use. Resident #314 stated she has had it for a couple of days in her room in the drawer, and she administered it herself this morning (07/01/25). Interview on 07/02/25 at 2:21 PM with LVN P stated she worked on 07/01/25 on a 6:00 AM - 2:00 PM shift with Resident #314. LVN P stated she did not think she saw the medication on the table however seen it this morning (07/02/25) and asked Resident #314 where she got the medication and Resident #314 replied my family member brought it to me. LVN P stated Resident #314 had not had any complaints of irritation or change in her condition. LVN P stated she had medication on her cart to administer the mediation for Resident #314, she was surprised to see the medication on the bedside table. LVN P stated residents were not allowed to store medications in their rooms, when staff observed the medications, they should remove it immediately and report it. Allowing medications to be stored in resident rooms placed residents at risk of overuse, overdose which can affect their care. LVN P stated nurses are ultimately responsible to ensure all medications are stored properly. 2. Record review of Resident #324's face Sheet, dated 07/03/24, revealed the resident was a [AGE] year-old female who was admitted on [DATE]. Review of Resident #324's MDS dated [DATE] revealed the resident's cognition was intact with a BIMS score of 15. Resident #324 required assistance with activities of daily living care. MDS indicated Resident #324 was not able to self-administer mediations. Resident #324 had diagnoses that included: Pneumonia (infection in the lungs), high blood sugar, and high blood pressure. Record review of Resident #324's order summary report dated 07/03/25 revealed she did not have an order for Clotrimazole vaginal antifungal cream. Interview on 07/01/25 at 12:25 PM with Resident #324 revealed resident in bed with tube of Clotrimazole vaginal antifungal cream at her bedside table. Resident #324 stated she did not know of the cream at the bedside table, and had a headache and did not want to speak with surveyor at this time. Interview on 07/02/25 at 3:26 PM with LVN O revealed she had worked 6:00 AM -2:00 PM shift on 07/01/25 however, she had not received any reports of Resident #324 itching or skin irritation; she further stated it could be possible that family had brought the medication. LVN O stated she had been in the room with Resident #324 but had not noticed the medication, and CNAs had not reported it in the room. LVN O stated if there were any medications found in residents' rooms, all staff were required to remove the mediation and report it. LVN O stated when residents have medications in their possession it placed them at risk of misuse of medications. Interview on 07/02/25 at 3:51 |

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|---|---|---|---|
| | 676358 | A. Building<br>B. Wing | 07/03/2025 |

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

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observation, interview, and record review, the facility failed to provide food prepared by methods, which conserved nutritive value, flavor, and appearance for one of one pureed meal observed for nutrition. The Dietary Aide failed to ensure the pureed lunch meal on 07/02/25 was prepared according to the recipe to conserve nutritive value and flavor. The failure could place residents, who were on a pureed diet, at risk for a decrease in nutritive status, loss of appetite, decreased intake, and unwanted weight loss.Findings included: Observation on 07/02/25 at 10:02 AM of the Dietary Aide preparing the pureed lunch revealed she put breaded chicken fried steak patties into a blender. She then blended the mixture, adding 4 scoops of white gravy. The Dietary Aide then added the mixture to molds. Record review of the recipe titled Pureed Chicken Fried Steak reflected:Ingredients: Beef Chicken Fried Steak, Water, Beef BaseCombine beef base with water to make beef broth. Place prepared fried steaks in a clean and sanitized food processor. Gradually add broth as needed and blend until smooth. *Note: Any liquid specified in the recipe is a suggested amount of liquid (if needed). Some recipe items will require no liquid added to achieve the desired consistency. 1. If product needs thinning, gradually add an appropriate amount of liquid (NOT WATER) to achieve a smooth, pudding or soft mashed potato consistency. 2. If the product needs thickening, gradually add a commercial or natural food thickener (ex, potato flakes or baby rice cereal) to achieve a smooth, pudding or soft mashed potato consistency. 3. Follow any facility policies/procedures, such as the puree volume method procedure, to ensure a correct portion is served. Top pureed foods with appropriate sauces or gravies, as needed, to ensure adequate moisture for safe consumption and enhanced flavor. Interview on 07/02/25 at 10:20 AM with the Dietary Aide revealed she was notified by the Dietary Manager that she would prepare the puree with surveyor. The Dietary Aide stated she was instructed to use the gravy with the chicken fried steak to prepare the entre. The Dietary Aide revealed the menu for pureed chicken fried steak called for water and beef base, and that she should have followed the recipe instead of using the gravy. According to The Dietary Aide, not following the recipe would place residents with puree diets at risk of not eating their meal due to the flavor or taste. Observation and interview with Dietary Manger on 07/02/25 at 12:57 PM of lunch trays, both pureed and regular texture, revealed chicken fried steak, mashed potatoes, and spinach and apple crisp and roll. Upon tasting the pureed meal, The Dietary Manager stated the spinach was without any flavor, just tasted like spinach. The Dietary Manager further revealed the pureed chicken fried steak was not smooth, that it contained grizzled parts. When asked about the recipe, The Dietary Manager stated she expected the aide to have followed the recipe and used the beef broth. The Dietary Manger stated the gravy was to add on top prior to serving. The Dietary Manager stated she was responsible for ensuring the staff followed the recipe and ensuring the pureed meal was smooth in texture, not doing so placed residents on pureed diets at risk of choking and refusing to eat when the meal did not have any taste or flavor. Record review of the facility's policy titled Nutrition Services revised 02/06/24 reflected:Recipes will be used when preparing menu items. 1. Recipes (in appropriate portion sizes) for each menu cycle are available and maintained in the facility. 2. Recipes will be printed to scale according to information derived from resident tray tickets and current census. 3. Nutrition Services employees are expected to use and follow the recipes provided. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 1 of 2 residents (Resident #8) observed for infection control. CAN M failed to perform proper hand hygiene while providing incontinence care to Resident #8.This failure could affect the resident by placing them at risk for worsening conditions and cross contamination. Findings included:Record review of Resident #8's face sheet, dated 07/03/25, revealed Resident #8 was admitted to the facility on [DATE].Record review of Resident #8's Comprehensive MDS assessment, dated 05/25/25, revealed Resident #8 had cognition intact with a BIMS score of 15. Resident #8 was noted to be dependent on staff for toileting, with substantial/max assistance with sit to stand, chair to bed transfer, and toilet transfer. Resident #8 was always incontinent of urinary and bowel. Active diagnosis included Stroke, Heart Failure, High Blood Pressure, High Blood Sugar, Hemiplegia or Hemiparesis (paralysis that affects only one side of the body), anxiety disorder and Chronic Obstructive Pulmonary Disease. Review of Resident #8's care plan, dated 07/03/25, revealed Resident #8 had Impaired Physical Mobility related to history of Paraplegia evidenced by general weakness. Goal: Maintain or improve physical function in Bed Mobility, Transfer, Ambulation, Locomotion, and Range of Motion. Intervention: Provide appropriate level of assistance to promote safety of resident. Resident #8 had Self Care Deficit related to limited joint mobility interfered with hygiene, and causing resident to have higher risk of skin breakdown. Goal: Maintain or improve self-care area of dress, grooming, hygiene, and bathing. Intervention: provide assistance with self-care as needed. Resident #8 at risk for problems with elimination evidenced by usual bowel pattern: daily. Goal: Resident's elimination status will be maintained or improved. Intervention: Assist to toilet as needed. Uses a brief. Resident #8 at risk of skin breakdown evidenced by Incontinent of bowel, always incontinent to bladder, confined to bed and chair most of the time, bed mobility and transfers: extensive. Goal: remain clean and intact skin. Interventions: apply protective or barrier lotion after incontinence. Keep skin clean, dry, and free of irritants. Resident #8 at risk of Infection Control evidenced by Enhanced Barrier Precautions every shift. Goal: Prevent spread of Multidrug-resistant Organisms. Intervention: Enhanced Barrier Precautions: gown and glove use during high-contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, wound care, and any skin opening requiring a dressing. Interview on 07/01/25 at 3:02 PM with Resident #8 revealed her saying I will not say I am good because no one comes to help me. Been here 2 months and it has been like this the whole time. I am paralyzed from my stroke on the right side and need help. I need to be changed right now so I can go therapy, and it has been a couple of hours since I was last changed. I think the last time I was changed was around 10:00 am before my therapy. My head nurse came in and I told her I need changed & they still have not come back in (over an hour ago). They do not check on me unless they are giving medications. I do have painful areas on butt from not being changed and laying/sitting all day. Was put in chair around 10 am and left there. This is what happens every day. Observation on 07/01/25 at 3:27 PM of incontinent care for Resident #8 revealed CNA M and CNA N completing hand hygiene and donning gown and gloves. As Resident #8 was transferred to her bed, it was revealed that her brief was soaked through onto a blanket placed on her wheelchair; stool was present. Resident #8 was rolled to her side then CNA M used Peri wash to clean resident starting at her buttocks cleaning the feces first. With dirty gloves CNA M reached into the wipes to pull more after cleaning feces. CNA M did not stop to remove the dirty gloves or wash his hands. CNA M then cleaned Resident #8's vaginal area while using the same gloves. CNA M continued with dirty gloves and applied cream to Resident #8's buttocks and vaginal crease, with same gloves and without washing his hands CNA M placed Resident #8 in a clean brief. CNA M then did not wash his hands but applied new gloves to dress Resident #8 with a new gown. CNA M grabbed a sheet off the bed and replaced the sheet on the wheelchair padding. Interview on 07/01/25 at 3:58 PM with CNA M revealed during peri care, I was supposed to get wipes out prior to beginning the incontinent care, peri wash, wipe from the front to the back. Today I started at the back. The reason that I did that for her, due to the protruding stomach so she can't lay back. After I did her back, then I did her front. I was supposed to change my gloves when I was done cleaning bowel movement and wash my hands before placing on new gloves however, I had 2 pairs of gloves on. You can wear 1 or 2 pairs of gloves, it's optional. I forgot to change my gloves after the bowel movement. I'm sorry. CNA M further stated |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Based on observation, interview, and record review the facility failed to ensure it was 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 from each resident's bedside and toilet and bathing facilities for 7 of 7 Halls checked for functional call light system (Halls 100, 200, 300, 400, 500, 600, and 700). The facility failed to ensure there was a working call light system available to residents to use after a weather-related storm occurred on 06/25/25 which caused the call light system to stop functioning. This failure placed residents at risk of not receiving timely care/assistance, falls, fall related injuries, head trauma, and hospitalization. Findings included: Interview and observation on 07/01/25 at 10:23 AM of Resident #57 revealed she was sitting in her wheelchair next to her bed and had a family member sitting in a chair in front of her. Resident #57 had a ringing bell on her bedside table that was in front of her. Resident #57's Family Member said that he was at the facility every day for hours and noticed a few days ago the resident was given a call bell to use since the call light system was out. Resident #57's Family Member said he was not sure what happened or why the call light system was out. Interview and observation on 07/01/25 at 10:48 AM with Resident #23 revealed she was lying in bed and had her bedside table near her with a call bell on it. Resident #23 said she call light system went out 4 days ago and she was given the call bell to use until it worked again. Interview and observation on 07/02/25 at 2:15 PM with Resident #87 revealed she was sitting on the side of her bed and had a ringing bell tied to a string connected to her bed. Resident #87 said she heard the call light system was out, so she was told to use the bell that was given to her. Resident #87 said the call light system went out a few days ago because of the storm. In a confidential group interview on 07/01/25 at 2:33 PM with 5 total residents revealed the call light system at the facility had not worked for the past 4 days. The residents were told that a blast of thunder during a storm the other night had knocked out the system. The residents said they were told the parts to fix the system were not available right now, so they were all given bells to use to get staff's assistance or attention instead. The residents said the staff were taking a long time to come to help them because it was hard for them to hear where the ringing bell was coming from. One resident explained that she had to go to the doorway of her room, almost out in the hall, to ring her bell so that staff would come to see what she needed help with. Interview on 07/02/25 at 10:41 AM with LVN A revealed a thunderstorm one day last week caused the electricity to go out at the facility and that caused the call light system to stop functioning. LVN A said staff handed out call bells for residents to use in the meantime. LVN A said he was also in-serviced to round on residents every 30 minutes as well. Interview on 07/02/25 at 10:50 AM with ADON B revealed she was on vacation last week but heard that the facility suffered through bad weather which caused the call light system to stop working. ADON B said when she came to work on Tuesday (07/01/25), all the residents had call bells and staff were told to check on their residents every 15-30 minutes. Interview on 07/03/25 at 9:54 AM with the HK Supervisor revealed he received a call from one of the staff on Wednesday night last week (06/25/25) saying the call lights were out on one of the halls. The HK Supervisor said he came to the facility to see which ones were being affected and not working. The HK Supervisor said he found a few rooms on the 300-hall that were not working, and those residents were moved to different rooms in the facility to where the call lights were working. The HK Supervisor said the next day (06/26/25) he came to work at the facility and found that something else happened to the motherboard of the call light system because he found more rooms that were affected all over the building. The HK Supervisor said the facility called their vendor to come and check on the system and were told that it would take two weeks to fix because the part had to be ordered. The HK Supervisor said when the facility was told about that, he said the facility ordered enough call bells for every resident to have one and they were passed out to each resident. The HK Supervisor said each resident received a call bell by Thursday evening (06/26/25). The HK Supervisor said staff were in-serviced to round on residents every 30 minutes because the call light system was not working through the whole facility. Attempted interview on the phone on 07/03/25 at 10:04 AM with the Maintenance Director revealed he did not answer and did not call back prior to exit. Interview on 07/03/25 at 2:19 PM with RN D revealed she was working Wednesday night (06/25/25) when the storm came through the area. RN D said the lights went out and the staff noticed resident call lights were not working all over the building, so they reported it to the maintenance department. RN D said the facility staff began rounding on residents more frequently and checking on them every 15-30 minutes. RN D said the next day, all residents were given call bells to use but the frequent rounds continued |