STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676483	A. Building B. Wing	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ventana by Buckner	8301 N. Central Expressway Dallas, TX 75201

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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure residents received proper treatment and care to maintain mobility and good foot health for 1 Resident (Resident #1) of 6 residents reviewed for foot care. The facility failed to provide adequate foot care for Resident #1 who had a standing order for podiatric services. Resident #1's toenails were chipped, thick, and long. This failure could put residents at risk for infection, impaired mobility, and poor foot health as well as a decline in their quality of life. Findings included: Record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected Resident #1 was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included hypertension (elevated blood pressure), anxiety (a normal human emotion, but it can become a disorder when feelings of worry and fear are intense, persistent, and interfere with daily life), and Vascular dementia, moderate, with psychotic disturbance (Dementia: a decline in mental ability severe enough to interfere with daily life). Resident #1 had a BIMS score of 10/15 which indicated Resident #1's cognition was moderately impaired. Further review revealed Resident #1 needed supervision or touching assistance for personal hygiene. Review of Resident #'1s Comprehensive Care Plan, created date 11/25/24, reflected the following: Problem: [Resident #1] requires Extensive assistance required with bathing, hygiene, dressing, and grooming. Goal: [Resident #1] Will be odor free, dressed and out of bed daily over the next 90 day. [Resident #1] will assist with ADLs to the highest degree possible. Intervention. Podiatrist to examine feet and trim nails. Schedule appointment as needed per physician's orders. STATUS: Active (Current). Record review of doctor orders revealed Resident#1 had a standing order dated (11/11/24) for podiatric referral May have . podiatry evaluation and treatment as indicated Notes: Instructions: Therapeutic Range: Source: Nursing Protocol as Needed Starting 11/12/2024. Review of the podiatry Schedule for visit date: 06/04/25 under title Patients with ‘do not treat (DNT)' Status revealed Resident #1 DNT date 03/27/25, and DNT reason No Consent on file. Review of the last six months weekly skin assessment revealed no indication of Resident #1's toenails status. An observation and interview on 07/15/25 at 09:17 AM revealed Resident#1 was lying in bed. CNA A removed Resident #1's socks during the morning routing care to get him out of bed. Resident #1's toenails #2, #3, #4, and #5 on both feet were long approximately 0.4 centimeter in length extending from the tip of his toes. Resident #1's both feet toenails #4, and #5 were growing out sideways; toenails #3 was growing straight, and #4 was curling forward. Resident #1's left big toenails showed signs of separation from the nail bed at the base of the nail plate. When asked if he would like his toenails trimmed, Resident #1 stated sure. Interview on 07/15/25 at 09:35 AM CNA A stated it was his responsibility to let the nurse know about the residents' toenails needing to be trimmed. He stated he had been working with Resident #1 for few months but did not notice that his toenails needed trimming. CNA A stated the risk when the toenails got bigger, the Resident could be uncomfortable. Interview on 07/15/25 at 09:41 AM RN B looked at Resident #1 toenails and stated they were long and chipped, and needed a podiatry consult. She stated nurses do weekly skin assessment and report to SW and the SW scheduled the consult. RN B stated Resident #1 should be on the podiatry consult list. RN B stated the podiatric services came in every three months to residents' toenails care. She stated last time she did the skin assessment on Resident#1 was last week, during which she did not noticed his toenails condition. RN B stated the risk to Resident #1 was he could scratch himself, potential skin issue, or if the toenails got cut in the shoes will be uncomfortable. Observation on 07/15/25 at 12:07 PM with the SW revealed she checked the podiatry referral file. Interview with the SW revealed she did not see Resident#1 name on the referral list. The SW stated the referral was sent, and the podiatric services asked on 3/28/2025 for a consent. She stated, she asked Resident #1's family member to fill out a consent but never got it back. The SW stated she tried to contact them again but did not have the document for the day of the request for the consent. When asked about the second quarter podiatry scheduled treatment, she stated the consent was not singed yet. She stated her assistant will be able to provide the reason. Interview on 07/15/25 at 12:28 PM the SWA stated, she could not remember any referral done for Resident #1, and there was an order. She stated it was the responsibility of the SW, and she was just helping her. Observation revealed the SWA searched Resident #1's file in the system. Interview revealed Resident # 1 was referred to podiatry. The SWA stated Resident # 1 was not seen during first visit of the year on 03/28/25, and on the second visit on June 4, 2025, because there was no consent done. When asked for the follow up with the family for the consent, she stated, she contacted the family member after the first visit over the phone and

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of infection of communicable diseases and infections for one of one resident (Resident #1) reviewed for infection control. The facility failed to ensure CNA A performed hand hygiene with gloves change, while providing incontinence care to Resident # 1. These failures could place residents at-risk of cross contamination which could result in infections or illness. Findings included: Record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected Resident #1 was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included hypertension (elevated blood pressure), anxiety (a normal human emotion, but it can become a disorder when feelings of worry and fear are intense, persistent, and interfere with daily life), and Vascular dementia, moderate, with psychotic disturbance (Dementia: a decline in mental ability severe enough to interfere with daily life). Resident #1 had a BIMS score of 10/15 which indicated Resident #1's cognition was moderately impaired. Further review revealed Resident #1 urinary continence/ bowel continence, always incontinent. Review of Resident #'1s Comprehensive Care Plan, created date 11/25/24, reflected the following: Problem: [Resident #1] requires Extensive assistance required with ., hygiene, . Goal: [Resident #1] Will be odor free, dressed and out of bed daily over the next 90 day. [Resident #1] will assist with ADLs to the highest degree possible. Intervention. Assist with ADLs. Observation on 07/15/25 at 09:17 AM of Resident #1's incontinent care, provided by CNA A revealed Resident #1 was lying in bed. CNA A entered Resident #1's room, donned gloves, got a clean brief, Resident #1's shoes, clothes, adjusted the bed, and got trash can next to the bed. CNA A removed gloves, donned clean gloves, without any form of hands hygiene. CNA A uncovered Resident #1 got the clean brief and put it on the bed. CNA A unfastened Resident #1's brief and pushed it between Resident's legs. CNA A cleaned Resident #1's front area with wipes, one at a time, and pushed the wipes between Resident #1's legs. CNA A helped Resident #1 turn to his right side. CNA A removed the dirty brief; the brief was wet with urine; put it in the trash can and cleaned Resident #1's buttocks area using one wipe per stroke. CNA A removed gloves, donned clean gloves without any form of hands hygiene, and put the clean brief on Resident #1. CNA A changed gloves without any form of hands hygiene and proceeded to get Resident #1 dressed, and out of his bed to wheelchair. Interview on 07/15/25 at 09:35 AM CNA A acknowledged he was changing gloves without any form of hands hygiene during Resident #1's incontinent care. CNA A stated he washed his hands after he finished the morning care for another resident, before coming to Resident #1's room. CNA A stated he was supposed to follow proper hand hygiene and wash or sanitize his hands before putting on the clean gloves. He stated that adhering to proper hand hygiene was important to prevent the spread, and development of infection to residents. In interview on 07/15/25 at 11:06 AM the DON stated infection control was important during residents' care. The DON stated during care the staff were supposed to sanitize hands upon entering the resident's room. The DON stated the staff were expected to complete hand hygiene before care and after care, she also stated during incontinent care the staff were supposed to change gloves and use hand sanitizer. The DON stated hand hygiene was to be completed for infection control. Record review of the facility's policy, revised 01/23/25, and titled Hand Hygiene, reflected, Hand hygiene is the most important procedure for preventing the spread of infections. Hand hygiene should be performed: Upon arrival at the workplace and before going home. After using the toilet, blowing nose, and covering a cough or sneeze. Before and after eating. Before and after client contact. After removing gloves. Before invasive procedures. After touching contaminated items.