STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676036	A. BUILDING _____ B. WING _____	06/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VISTA RIDGE NURSING & REHABILITATION CENTER	700 E VISTA RIDGE MALL DR LEWISVILLE, TX 75067

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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one (Resident #1) of five residents reviewed for quality of care. The facility failed to ensure Resident #1 received an x-ray as ordered following a fall on 05/29/20. An x-ray was ordered on [DATE] of Resident #1's right hip, but the x-ray was not obtained until the resident was transferred to the hospital on [DATE]. At the hospital the resident was diagnosed with [REDACTED]. This failure placed residents at risk of not receiving treatment for [REDACTED]. Findings included: Review of Resident #1's MDS assessment dated [DATE], reflected the resident was an [AGE] year-old female admitted to the facility on [DATE]. The resident's cognition was moderately impaired, and her [DIAGNOSES REDACTED]. The resident required the extensive assistance of one staff for transfers. Review of Resident #1's Current Care Plans dated 02/13/20 and revised on 05/31/20, reflected the resident had a fall due to impaired mobility, weakness, and impaired safety awareness. Facility interventions included X-ray as order to rule out any fracture. Review of Resident #1's Incident Report dated 05/29/20 reflected the resident was found on the floor during rounds. an order for [REDACTED]. Review of Resident #1's Physician order [REDACTED]. Review of the 24-hour report dated 05/29/20 through 05/31/30 reflected Resident #1 had X-rays ordered on [DATE]. No results were noted. Review of Resident #1's Progress Notes dated 05/29/20 through 05/31/20 reflected: 05/29/20 5:00 a.m. Resident #1 was found on the floor during rounds, the physician was notified about the resident fall. The physician ordered X-ray for right hips two views. No other additional notes were documented concerning the follow-up of the x-ray. 05 /31/20 at 11:34 a.m. Resident #1 complaining of back pain, physician notified STAT X-ray ordered for pain in back. X-rays were not able to provide ETA (estimated time of arrival). A new order received to send resident to the ER (emergency room) for pain evaluation and treatment. Review of Resident #1's hospital records revealed a Radiological report for a CT Scan of the [MEDICATION NAME] and lumbar spine dated 05/31/20. which reflected acute superior T12 end plate fracture An observation on 06/03/20 at 11:05 a.m. revealed Resident #1 was lying in her bed. She said that she recalled falling, but did not recall going to the hospital. The resident said she did not want to get up today. When Resident #1 was asked why she did not want to get up she said it was because she had fallen. An interview with LVN B on 06/03/20 at 12:15 p.m. revealed he was assigned to Resident #1 on 05/28/20 and 05/29/20 for the 10:00 p.m. - 6:00 a.m. shift. LVN B said he was informed by the CNA around 5:00 a.m. that Resident #1 was on the floor. LVN B said he assessed Resident #1 and she appeared to have no injuries. He stated he assisted her back into the bed, called the physician, completed the incident report, and called the responsible party. LVN B said the physician ordered an X-ray of the right hip. LVN B stated he called the X-ray company, completed the paperwork, reported to the oncoming nurse in charge and went home. LVN B said he was not in charge of Resident #1 again. LVN B was asked what the policy for physician orders [REDACTED]. An interview with LVN C on 06/03/20 at 12:43 p.m. revealed on 05/29/20, she was the nurse in charge for Resident #1 for the 6:00 a.m.-2:00 p.m. shift. LVN C said she was aware that Resident #1 had fallen but did not recall any x-rays that had been ordered. LVN C was asked about following up on the fall and physician orders [REDACTED].#1 had x-rays the day before (05/28/20). LVN C said the X-Rays were negative, she did not think about looking for any other orders. LVN C said she followed up on her assessment for pain of Resident #1 due to the fall on 05/28/20. LVN C said the resident did not complain of any pain and she was up walking with her walker. LVN C was asked about the policy for physician orders, she said when you receive an order for [REDACTED]. RN D said she was told that Resident #1 had fallen, but she was not told about any X-rays that had been ordered. RN D said she assessed and followed-up on Resident #1 for a change in condition. RN D stated if she knew there were X-rays ordered she would have called and found out why the X-rays had not been done, but no one told her. RN D was asked if she checked the 24-hour report and she said, no she did not. An interview with LVN E on 06/03/20 at 12:43 p.m. revealed she was the nurse in charge on 05/30/20 for the day shift and 05/31/20 for the day shift. LVN E said that she had assessed and followed-up on Resident #1 after her fall on 05/29/20. LVN E said that she had called and spoken to the X-ray company about the X-rays that had not been completed on 05/30/20 and was told the X-ray company was backed-up. LVN E stated she had not reported this delay to the physician. LVN E said Resident #1 appeared fine and she thought the Administrator knew about the X-rays not being done. LVN E said on 05/31/20 she assessed Resident #1 in the morning and she was fine, offering no complaint, but around 11:00 a.m. Resident #1 started complaining of pain in her low back. LVN E had the RN weekend supervisor assessed the resident. LVN E said the resident was sent to the hospital for further assessment. An interview with LVN F on 06/03/20 at 2:24 p.m. reflected she was the charge nurse for Resident #1 on 05/30/20 from 2:00 p.m. -10:00 p.m. LVN F said she was unaware that Resident #1 had any X-rays ordered. LVN F was asked what the policy for physician orders [REDACTED]. An interview with RN G on 06/03/20 at 3:30 p.m. revealed she was the weekend RN supervisor on 05/30/20 and 05/31/20. RN G said she had assessed Resident #1 on 05/31/20 when LVN E had reported the resident was experiencing pain in her back. RN G said she assessed the resident and called the physician about getting an X-Ray for her back. RN G was told by the X-ray company they were backed-up. When the Administrator had called to check on the other X-rays, RN G said the Administrator made it STAT, but the X-ray company could not give an ETA on when the x-ray would be performed. The Administrator said to call the physician and send Resident #1 to the hospital. RN G said she was aware of the X-rays that had been ordered on [DATE].She stated she had been on the phone for 45 minutes on 05/30/30 trying to follow-up on those x-rays. RN G stated the Administrator had texted her about it, but she had not gotten back with him. An interview with LVN A on 06/03/20 at 11:20 a.m. revealed she was off on 05/29/20 when Resident #1 had fallen, when she returned to work on Monday 06/01/20 it was reported to her that Resident #1 had a Compression Fracture of T-12. When LVN A was asked about the policy for following physician orders, LVN A said if you get an order you were to see that the order was followed. The LVN said if you could not complete the physician order [REDACTED]. LVN A said she had previously had problems with getting X-rays completed at the facility. An interview with the Administrator on 06/04/20 at 11:45 a.m. revealed he had called to check and had sent a text concerning the results of Resident #1's X-rays on Saturday morning, 05/30/20, but the weekend RN supervisor said she had no results and would call and check. The Administrator stated he did not hear anything back. On Sunday morning, 05/31/20, he called to check on the results of the X-rays and was told by the RN supervisor that she had an order for [REDACTED]. The Administrator said he called back and found out about no ETA given, so he told her to call the family and send her to the hospital. The Administrator said he did not understand why they did not follow-up, it was in the 24-hour report. An interview with the primary care Physician on 06/04/20 at 1:00 p.m. revealed he was aware that both sets of X-rays had been ordered for Resident #1. The Physician said once he gave the orders to the nurse, it was up to the facility to get the test completed and to follow-up on the results and let him know. If the facility did not follow-up, the Physician would have no way of knowing if the tests were completed or not. The Physician said he was aware that Resident #1

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

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.

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) had a fracture of T-12 and was to see an Orthopedic Surgeon for a follow-up, but the facility had not contacted him to let him know the hip X-rays were not getting done. When the Physician was asked about the length of time that the facility let pass without completing the hip X-ray, he replied he was glad her hip was not broken. An interview with the DON on 06/04/20 at 12:00 p.m. revealed she expected her nurses to follow physician orders. The DON said if the nurse could not complete the order, the nurse should communicate with the physician, Administrator and the DON. When ask concerning time frames for x-rays, the DON said if the x-ray is ordered non-STAT, the x-ray is completed within 24 hours, but if the x-ray is ordered STAT then it has to be completed within 5 hours. Review of the facility's policy for Radiology and other Diagnostic Services, undated, revealed, Radiology and other diagnostic services are available to residents to meet their needs for diagnostic, treatment and prevention. The facility is responsible for the quality and timeliness of the services. Review of the facility's policy for Quality of Care, undated, revealed, The facility provides the necessary care and services to ensure that each resident attains or maintains the highest practicable physician, mental, and psychological well-being in accordance with the resident's comprehensive assessment and plan of care