STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675611	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Dallas	550 E Ann Arbor Ave Dallas, TX 75216

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675611	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Dallas	550 E Ann Arbor Ave Dallas, TX 75216

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 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 observation, interview and record review the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for three of five residents (Resident #1, #2, and #3) reviewed for reasonable accommodation of needs. The facility failed to ensure the call light system in Resident #1, #2, and #3's rooms was in a position that was accessible to the residents on 09/09/25. This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.Findings include: Record review of Resident #1's Face Sheet, dated 09/09/25, reflected she was an [AGE] year-old male admitted to the facility on [DATE]. Relevant diagnoses included Acute Respiratory Failure (lack of oxygen) and unsteadiness on feet. Record review of Resident #1's Quarterly MDS assessment, dated 08/26/25, reflected he had a BIMS score of 9 (moderate cognitive impairment). For ADL care, it reflected the resident required total assistance. Record review of Resident #1's Comprehensive Care Plan, dated 08/26/2025, reflected the resident was a fall risk and one of the interventions was to ensure call light was within reach of the resident and to encourage the resident to use it. In an observation on 09/09/25 at 8:30 AM, Resident #1 was observed lying in bed and his call light was located under his bed, out of reach from the resident. Record review of Resident #2's Face Sheet, dated 09/09/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included muscle weakness and unsteadiness on feet. Record review of Resident #2's Quarterly MDS assessment, dated 09/01/25, reflected she had a BIMS score of 5 (severe cognitive impairment). For ADL care, it reflected the resident required total assistance. Record review of Resident #2's Comprehensive Care Plan, dated 09/04/25, reflected the resident was a fall risk and one of the interventions was to ensure call light was within reach of the resident and to encourage the resident to use it. In an observation on 09/09/25 at 8:31 AM, Resident #2 was observed lying in bed and his call light was located approximately 3 feet away from his bed, out of reach from the resident. In an interview and observation on 09/09/25 at 8:33 AM, CNA Q was shown the call lights location for Resident #1 and Resident #2. She located the call lights and placed them alongside the residents. She stated the call light needed to be placed within reach of the resident so they could contact someone if they neededassistance. In an interview on 09/09/25 at 8:35 AM, LVN C was advised of the call lights for Resident #1 and Resident #2 not being within reach of the residents. She stated staff checked the resident rooms at least every 2 hours to ensure call lights were within reach of the resident. She stated if the resident's call light was not within reach, they could not contact anyone if they needed help. She stated Resident #1 and Resident #2 were fall risk. Record review of Resident #3's Face Sheet, dated 09/09/25, reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included muscle weakness and unsteadiness on feet. Record review of Resident #3's Quarterly MDS assessment, dated 07/12/25, reflected she had a BIMS score of 12 (moderate cognitive impairment). For ADL care, it reflected the resident required total assistance. Record review of Resident #3's Comprehensive Care Plan, dated 07/22/25, reflected the resident was a fall risk and one of the interventions was to ensure call light was within reach of the resident and to encourage the resident to use it. In an interview and observation on 09/09/25 at 8:33 AM, LVN P was shown the call light for Resident #3 hanging behind the back of the resident bed frame and out of reach of the resident. Resident #3 stated she had been looking for her call light all night. LVN P placed the call light within reach of the resident and stated the call light needed to be placed within reach of the resident so she could contact staff if she required assistance or had an emergency. In an interview on 09/09/25 at 9:00 AM, the DON was advised of Resident #1, Resident #2, and Resident #3 not having their call light within their reach. She stated the nursing staff checked room at least every hour and checked for call lights being within reach. She stated they had placed clips on the call light to ensure they stayed in placed. She stated the call lights needed to be within reach of the resident so they could contact staff if they needed any assistance. Record review of the facility's policy on Call Light/Bell (08/03/21), revealed It is the policy of this facility to provide the resident the means of communication with nursing staff. Leave the resident comfortable. Place the call device within reach resident's reach before leaving room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675611	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villages of Dallas	550 E Ann Arbor Ave Dallas, TX 75216

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident was free from physical restraints not required to treat the residents' medical symptoms as was possible for one of five residents (Resident #4) reviewed for physical restraints. The facility failed to ensure Resident #4 had physician orders for the bolster mattress on her bed. This failure could place residents at risk of not having an environment that was free of restraints which could result in injury. Findings include: Record review of Resident #4's face sheet, dated 09/09/25, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4's relevant diagnoses included unsteadiness on feet and repeated falls. Record review of Resident #4's Quarterly MDS assessment, dated 08/18/25, reflected she had a BIMS score of 99 (unable to complete the interview). For ADL care, it reflected the resident required extensive assistance. Record review of Resident #4's Comprehensive Care Plan, dated 05/22/25, reflected the resident was a fall risk and an intervention included the use of a bolster mattress for safety. Record review of Resident #4's physician orders, dated 09/09/25, reflected no physician orders for the bolster mattress. Record review of the facility's incident report for May 2025, June 2025, July 2025, and August 2025, revealed no falls or unknown injuries for Resident #4. In an observation on 08/12/25 at 10:10 AM, Resident #4 was observed lying in bed. The resident's bed had padding on the sides of the bed that measured approximately six inches in height and six inches in thickness. In an interview on 09/09/25 at 11:19 AM, the DON was advised that Resident #4 was observed with a bolster mattress and no physician orders was observed on file. She stated the resident was provided the equipment because she was a fall risk. She stated she had shown the bolster mattress to Resident #4's Responsible Party and they agreed that it would be a good device for the resident. She stated she added it to the resident's care plan, but she forgot to get the physician orders for it. She stated it was her sole responsibility. She stated the resident required physician orders for the equipment because it was needed. The facility's policy RESTRAINTS (06/17) reflected It is the policy of the facility to refuse to restrain residents for any cause. Should a resident have cause for need of a restraint, the physician will be notified immediately, and Texas state regulations will be followed