

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675611	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2026
NAME OF PROVIDER OR SUPPLIER The Villages of Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 2 (200 Hall and 3000 Hall) of 2 hallways reviewed for accidents and hazards.1. The facility failed to ensure that 3 mechanical lifts were locked and secured when not in use on the 200 Hall. There was 1 mechanical lift and 1 wheelchair that blocked entry to the Fire Exit door on the 200 Hall.2. The facility failed to ensure that 3 mechanical lifts were locked and secured when not in use on the 3000 Hall.This failure could place residents, visitors and staff at risk of falls and/or injuries. Findings Included:Observation of the 200 Hall on 07/14/26 at 10:23 PM revealed 1 unlocked and unsecured mechanical lift parked on the hallway in between 2 resident rooms.Observation of the 200 Hall on 07/14/26 at 11:13 AM revealed 2 unlocked and unsecured mechanical lifts parked at the end of the hallway.Observation of the 3000 Hall on 07/14/26 at 12:19 PM revealed 3 unlocked and unsecured mechanical lifts parked on 2 hallways outside of resident rooms.Observation of the 200 Hall on 07/14/26 at 12:24 PM revealed 3 unlocked and unsecured mechanical lifts and 2 wheelchairs parked at the end of the hall. There were 1 Hoyer Lift and 1 wheelchair that blocked the entrance to the Fire Exit Door. During an interview on 07/14/26 at 1:03 PM with CNA A, she stated that she had been employed at the facility for 7 years. CNA A stated that she was assigned to the 200 Hall on 07/14/26. CNA A stated that she was unaware that the 3 mechanical lifts parked on the 200 Hall were unlocked and unsecured that day. CNA A stated she was unaware that 1 unlocked mechanical lift and 1 wheelchair were parked in front on the Fire Exit Door on the 200 Hall on 07/14/26. CNA A stated she was unaware that the 3 mechanical lifts parked on the 3000 Hall were unlocked and unsecured on 07/14/26. CNA A stated that she had taken in-service trainings on mechanical lift safety and storage, and fire safety. CNA A stated that she did not remember when she had previously taken in-service trainings on mechanical lift usage, safety, storage and fire safety. CNA A stated that mechanical lifts should be locked and secure when they were not in use. She stated she would check the mechanical lifts every time she passed them to ensure that they were secure and always locked. CNA stated there should never be anything including unlocked and unsecured mechanical lifts and wheelchairs parked in front of any Fire Exit Doors in the facility. CNA A stated that if she observed a staff member store the mechanical lift, she would ask them if they ensured that the parked mechanical lifts were always locked when they were parked. CNA A stated if a mechanical lift was unlocked, there was a risk of it being moved by someone, which would cause the mechanical lift to roll. She stated another risk of having an unlocked and unsecured mechanical lift and wheelchair blocking the Emergency Exit Door, was it could cause people to have no access to exit the building through the Fire Exit Door. She stated the Fire Exit Doors throughout the facility should be always cleared including unlocked and unsecured mechanical lifts and wheelchairs. CNA A stated that someone could be harmed by an unlocked mechanical lift and may fall (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675611	Facility ID: 675611 If continuation sheet Page 1 of 6

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and receive broken bones, fractures, and bust their head, which can cause a serious injury or possible death. During an interview on 7/14/26 at 2:01 PM with LVN B, she stated that she had been employed at the facility for 10 months. LVN B stated that she was Full Time Nurse assigned to the 200 Hall on 07/14/26. LVN B stated that she was unaware that the 3 mechanical lifts parked on the 200 Hall were unlocked and unsecured on 07/14/26. LVN B stated she was unaware that 1 unlocked mechanical lift and 1 wheelchair were parked in front on the Fire Exit Door on the 200 Hall on 07/14/26. LVN B stated she was unaware that the 3 mechanical lifts parked on the 3000 Hall were unlocked and unsecured on 07/14/26. LVN B stated that she had taken in-service trainings on mechanical lift safety and storage, and fire safety. LVN B stated that she could not recall when she had previously taken in-service trainings on mechanical lift usage and safety and fire safety. LVN B stated she thought that the last In-Service Training she had taken was about 30 days ago. LVN B stated all mechanical lifts were to be always locked and secured when they were not in use. LVN B stated she did not work on the 3000 Hall, but the mechanical lifts on each hall should always be locked at secured. LVN B stated if she observed an unlocked mechanical lift, she would immediately park the mechanical lift and ensure it was in a safe area away from any hazards. LVN B stated mechanical lifts and wheelchairs or anything should never be placed in front of the Fire Exit Door to prevent hazards and access to the Fire Exit Door in case of an emergency. LVN B stated that she would ensure and tell other staff members that the mechanical lifts on the hallway adjacent to the 3000 Hall were always locked and secured when parked and not in use. LVN B stated that mechanical lifts should always be locked and secure, such as the hallways when they were not being used. LVN B stated that harm could be caused to anyone when a mechanical lift was unlocked, which included accidents and falls due to the unlocked and unsecured mechanical lift being moved and rolled. She stated that someone could be harmed by having a serious fall with injuries, such as someone's foot getting caught in the mechanical lift, and someone falling face and landing on the floor. LVN B stated harm such as cuts, bruises and fractures, which has potential for someone to be hospitalized due to a mechanical lift being on the hallway unlocked and unsecured. During an interview on 07/14/26 at 2:34 PM with the DON, she stated that she had been employed at the facility for 9 years. The DON stated that she was unaware that the 3 mechanical lifts parked on the 200 Hall were unlocked and unsecured on 07/14/26. The DON stated she was unaware that 1 unlocked mechanical lift and 1 wheelchair were parked in front on the Fire Exit Door on the 200 Hall on 07/14/26. The DON stated she was unaware that the 3 mechanical lifts parked on the 3000 Hall were unlocked and unsecured on 07/14/26. The DON stated that her expectation for all staff at the facility was to ensure that all mechanical lifts in the facility were to be locked and secured when they were parked and not in use. The DON stated that all staff have been educated and trained on the proper usage and safety of mechanical lifts, which included always locking at always securing them. The DON stated that all staff have been educated on Fire Safety, which included ensuring that the Fire Exit Doors were always cleared and free of any debris in case of an emergency. The DON stated that she could not recall when all staff received their last in-service training on mechanical lifts, safety, accidents and hazards and fire safety. The DON stated that she will reeducate staff with in-service training on mechanical lifts safety and storage and fire safety. The DON stated that the in-service training for staff would also include education on performing routine checks of the mechanical lifts in the building to ensure they were always locked. The DON stated the facility did not have a designated area for storage for the mechanical lifts in the building. She stated she would have to meet with management to locate designated areas for mechanical lift storage throughout the facility. The DON stated there was a risk to anyone in the facility to be injured due to an unlocked and unsecured mechanical lift. She stated the risk was the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident and/or staff could bump against the unlocked mechanical lift and cause an accident. The DON stated the risk of the Fire Exit Door being inaccessible in the event of an accident could prevent anyone from exiting the floor through that door during an emergency. The DON stated she felt that there was no harm caused to anyone in the facility due to the unlocked and unsecured mechanical lifts and blocked Fire Exit Door because there had not been any reported accidents or incidents at the facility. The DON stated that the facility did not have any policies regarding accidents and hazards. During an interview with the Administrator on 07/14/26 at 2:55 PM, he stated that the facility did not have a policy for accidents and hazards relating to mechanical lift safety and storage. The policies received on 07/14/26 were encrypted. So, an email was sent to the Administrator on 07/21/26 at 11:31 AM, requesting the facility's policy, Fire Safety relating to accidents and hazards. The surveyor did not receive a response from the Administrator on 07/21/26. Record Review of facility's policy revised May 2007 for Incident Accident Reporting, did not provide any information regarding accidents and hazards relating to mechanical lift safety and storage. Record Review of facility's policy revised July 2018, for Equipment Inspection and Maintenance, did not provide any information regarding accidents and hazards relating to mechanical lift safety and storage.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide maintenance services necessary to maintain a safe, sanitary, orderly, and comfortable for 2 of 2 areas (Shower Room and Utility Room) on the 200 Hall reviewed for safe, and clean environment.1. The facility failed to ensure the bed liner in the Shower Room on the 200 Hall was cleared from standing water on 07/14/26.2. The facility failed to ensure the sink in the Soiled Utility Room the 200 Hall was cleared from standing water and working properly on 07/14/26. These failures place residents at risk for a diminished quality of life, infection, and clean environment. Findings included: During an observation of the facility's 200 Hall Shower Room on 07/14/26 at 11:17 AM, the Shower Bed Liner underneath the Shower Bed had 4 puddles of standing water. The standing water appeared light brown in color. The Shower Bed Liner appeared to be white in color with areas that appeared to be brown and black in color. During an observation of the facility's 200 Hall Utility Room on 07/14/26 at 11:25 AM, the sink was filled with standing water. The standing water appeared light brown in color. There was a glove, plastic clear cup, and 2 other unknown items that were floating inside the standing water in the sink. The sink appeared to be white in color with dirt, which appeared to be brown in color. During an observation of the facility's 200 Hall Shower Room on 07/14/26 at 12:27 PM, the Shower Bed Liner underneath the Shower Bed had 4 puddles of standing water. The standing water appeared light brown in color. The Shower Bed Liner appeared to be white in color with areas that appeared to be brown and black in color. During an observation of the facility's 200 Hall Utility Room on 07/14/26 at 12:31 PM, the sink was filled with standing water. The standing water appeared light brown in color. There was a glove, plastic clear cup, and 2 other unknown items that were floating inside the standing water in the sink. The sink appeared to be white in color with dirt, which appeared to be brown in color. During an observation on 07/14/26 at 12:57 PM, a confidential resident was observed exiting her room on the 200 Hall with an empty soda can box. The confidential resident opened the door to the Utility Room and threw the empty soda can box into the trash can in the Utility Room on the 200 Hall. During a telephone interview with Resident #1's RP on 07/13/26 at 3:58 PM, she stated Resident #1 was admitted to the facility for 6 years. The RP stated she had washed her FM's hair on several occasions in the Shower Room on the 200 Hall. The RP stated on 07/12/2026, she provided her FM with a hair shampoo in the Shower Room on the 200 Hall. The RP stated on 07/12/26, the Shower Room on the 200 Hall had the same Shower Bed Liner with the puddles of brown water. The RP stated she mentioned her concerns to the facility staff regarding the standing water in the Shower Room and there had not been any changes. The RP stated she had not filed any Grievances with the facility regarding her concerns about the standing water in the Shower Bed Liner in the Shower Room on the 200 Hall. During a confidential interview with a resident at an undisclosed date at time, they stated she had been at the facility for an unknown timeframe. The resident stated she utilized the Shower Room on the 200 Hall to bathe, which was three times per week. The residents stated she was in a wheelchair but was independent and able to take showers independently. The resident stated the Shower Bed Liner in the Shower Room on the 200 Hall had, some yucky water puddles, which were brown with some kind of unknown substance in the water, and the was dirty and gross. The resident stated the puddles of water in the Shower Bed Liner had been there for an unknown period, but they have been there for some time. The resident stated she reported to staff about the Shower Bed Liner being dirty, but it did not make a difference. The resident stated she had not filed any Grievances with the facility regarding her concerns with the Shower Bed Liner in the Shower (continued on next page)		

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