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	04/16/2026

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident received food that is palatable, attractive, and at a safe and appetizing temperature for five of five residents in a confidential group of residents. The facility failed to provide palatable food served at an appetizing temperature to residents. This failure could affect the residents who ate food from the facility kitchen by placing them at risk of poor food intake and/or dissatisfaction with the meals served and weight loss.The findings included: During a confidential interview five residents stated that they had received cold food. Residents stated it was not dietary's fault as the dietary staff gets the food out, but the carts have sat on the hall for five to ten minutes before staff pass the trays Observation of food cart on 04/15/2026 at 12:25 PM, revealed an insulated food cart on hall 1-[NAME] with 10 food trays. Two staff members observed passing trays. During an interview on 04/16/2026 at 9:51 AM, CNA D stated that she had received one or two cold food complaints. CNA D stated that when she received a cold food complaint that she would take the tray and rewarm the tray in the microwave. During interview on 04/16/2026 at 10:50 AM, CNA E stated she had received complaints from residents stating that the food was cold, but it had been about two months. CNA E stated that the facility ordered new carts that were enclosed which helped with keeping the temperature of the food. CNA E stated that they asked the residents if they would like their tray to be reheated and residents were usually fine once the tray was reheated. Observation of test tray on 04/16/2026 revealed it left the facility kitchen at 12:49 PM, arrived on hall at 12:52 PM, and the last tray was served at 12:58 PM. State surveyor tested test tray at 1:03 PM which revealed mashed potatoes that were cold, chicken fried steak was room temp, and green beans that were room temperature. Record review of January, February and March 2026 grievance log reflected no complaints of cold food. Record review of January, February and March 2026 resident council minutes reflected no complaints of cold food. Record review of seven resident's weights reflected no significant weight loss noted. During interview on 04/16/2026 at 2:06 PM, DM stated that she had received complaints about cold food. The DM stated that dinner was the primary meal, because she originally had ordered one set of plate warmers, but they did not go into the dishwasher until 3PM and dinner meal service started at 5PM and they would not be ready. The DM stated that they ordered another set and covered the plates, utilized plate warmers and had enclosed carts. The DM stated that all the equipment was ordered two months ago and had not had a complaint since. The DM confirmed the test tray was not provided with a plate warmer. She stated that it contributed to the plate not being hot. The DM stated that her or the cook should monitor their trays to ensure they had the plate warmer. The DM stated that the risk to the residents for food being cold was loss of appetite and weight loss. During interview on 04/16/2026 at 3:02 PM, the ADM stated that his expectation of his staff was that food be served to residents at a safe and appetizing temperature. The ADM stated that cold food was a major topic from the residents last year, so he decided to spend about $30,000 on insulated meal carts, custom lids to fit on top of plates, and plate heaters. Additionally, he opened a steam table on floor two to assist with food temperatures as this facility had a heavy census and multiple floors.The ADM stated if food was not served at an appetizing temperature, it could have caused residents to not want to eat their (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	food which could have led to weight loss but was not aware of any residents who had weight concerns. Record review of invoices dated 3/12/2026 reflected four meal delivery carts, 10 sets of electric heat plates, 10 sets of plate covers for total of $31, 778. Requested meal service/preferred temperature policy via email on 04/16/2026 at 2:28 PM. Did not receive it prior to exit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen reviewed for food safety.The facility failed to discard spoiled items stored in the walk-in refrigerator.These failures could place residents at risk for food-borne illness, cross contamination, and infection.During an observation of the walk-in refrigerator on 04/14/2026 at 10:20 a.m., the following was revealed: 1 large clear bin of what appeared to be 29 yellow onions. The bin had no item description or expiration date and was marked with a delivery date of 02/25/2026. Seven items displayed black, fuzzy soot-like spots covering more than half of the surface, two had long green shoots extending from the ends, and six were soft, mushy, and slimy to the touch.1 large clear bin of what appeared to be several dozen lemons. The bin had no item description or expiration date and was marked with a delivery date of 03/30/2026. Two were soft, spongy, and mushy to the touch and two were wrinkled, bumpy, shriveled, and hard to the touch.During an interview on 04/14/2026 at 10:24 a.m., the DM stated that fresh fruits and vegetables were not labeled with expiration or discard dates. The DM indicated that staff determined whether produce was no longer safe for consumption by physically looking at it and would not use the item if it was bad. The DM further stated that, if a resident were to be served spoiled produce, they might get sick. During an interview on 04/16/2026 at 11:52 a.m., [NAME] A stated she would not use produce that looked spoiled and it could make the residents sick.In a record review of the facility's Infection Control Policy Food Service, dated 10/2025, revealed there was nothing about storing or identifying spoiled fruits or vegetables. Review of the U.S. FDA Food Code 2022 reflected: . Section 6-404.11 Products which are damaged, spoiled, or otherwise unfit for sale or use in a food establishment may become mistaken for safe and wholesome products and/or cause contamination of other foods.To preclude this, separate and segregated areas must be designated for storing unsalable goods.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that the medication error rate was not five percent (5%) or greater. The facility had a medication error rate of 6%, based on 31 opportunities and 2 errors, which involved 2 of 4 residents (Residents #49 and #35) and one of two staff (MA A) observed during medication administration for medication error. 1. MA A failed to administer Resident #49's MiraLAX Oral powder 17grm (for constipation) with the appropriate amount of fluid. MA A left the cup of medication with Resident #49. 2. MA A failed to administer Resident #35's MiraLAX Oral powder 17grm (for constipation) with the appropriate amount of fluid. These failures could place residents at risk for not receiving the therapeutic dosages of their medications as ordered by the physician and a decreased health status. Based on observation, interview and record review the facility failed to ensure that the medication error rate was not five percent (5%) or greater. The facility had a medication error rate of 5%, based on 31 opportunities, which involved 2 of 4 residents (Residents #49 and #35) and one of two staff (MA A) observed during medication administration for medication error.1. MA A failed to administer Resident #49's MiraLAX Oral powder 17grm (for constipation) with the appropriate amount of fluid. MA A left the cup of medication with Resident #49. 2. MA A failed to administer Resident #35's MiraLAX Oral powder 17grm (for constipation) with the appropriate amount of fluid. These failures could place residents at risk for not receiving the therapeutic dosages of their medications as ordered by the physician and a decreased health status. Findings include: Record review of Resident #49's quarterly MDS assessment dated [DATE], revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #49 had diagnoses which include: Hypertension (high blood pressure), cerebral vascular accident (stroke), and constipation (hard stool). Resident #49 was alert and oriented and able to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #49's physician's order, dated 04/13/2026, reflected MiraLAX Oral Powder 17 gm/scoop give one scoop every 24 hours as needed for constipation mix with four to eight ounces of fluid. Record review of the plan of care for Resident #49 dated 01/02/2026 reflected no goals related to self-administration of medications. Further review revealed no assessments related to self-administration of medicines for Resident #49. Observation on 04/14/2026 at 9:48 a.m., revealed MA A administered the following medication to Resident #49: MiraLAX 17 gm. was administered to Resident #49 by MA A with an undetermined amount of fluid. During the administration of the medication MA A did not stay in the room to observe Resident #49 finish drinking the fluid with medication provided in the cup. MA A did not follow up to assure Resident #49 had completed the medication. Record review of Resident #35's quarterly MDS assessment dated [DATE], revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #35 had diagnoses which include: Hypertension (high blood pressure), cerebral vascular accident (stroke), non-Alzheimer's dementia (confusion) and constipation (hard stool). Resident #35 had moderate cognitive impairment and was unable to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #35's physician's order, dated 04/02/2026, reflected MiraLAX Oral Powder 17 gm/scoop give one scoop every 24 hours as needed for constipation mix with four to eight ounces of fluid. Observation on 04/14/2026 at 9:58 a.m., revealed MA A administered the following medication to Resident #35: MiraLAX 17 gm. was administered to Resident #35 by MA A with an undetermined (did not measure the fluid, just filled up the unmarked cup) amount of fluid. In an interview on 04/14/2026 at 10:15 a.m., MA A stated she knew better than to give the medications without measuring out the appropriate amount of fluid. MA A stated she thought the cups offered 4 ounces of fluid, but was not sure, she had never measured the fluid, she just filled the unmarked cup up and gave it to Resident #49 and Resident #35 to drink. MA A stated she would have to slow down and be more thorough and stay with the residents while they take their medication. In an interview on 04/16/2026 at 9:33 a.m., the DON (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed the staff should be reading the medication administration record prior to and after giving the medication to be assured they were giving the correct medicines at the right time. The DON stated the medication administration record gave the staff all the information for type of medication, how much to give, and if it was by mouth, topical, or eye drops or nose spray. The MiraLAX was to be given with 4 to 6 ounces of fluid and if the cups were not marked, they should be measuring the amount the cup would hold to make sure the resident was getting the correct amount of fluid. The DON stated the staff should never leave the residents with their medications; part of the medication pass was to ensure the residents received the correct medication and assured they were taking it. Record review of the facility's policy and procedure Medication Administration, dated July 2020, reflected, It is the policy of this facility that medications shall be administered as prescribed by the attending physician., procedures: 2. Medications must be administered in accordance with the written orders for the attending physician. the seven rights of medications administration are as follows in order to ensure safety and accuracy of administration. 4. Right Dose-Medications are administered according to the dose prescribed.

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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 establish and 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 communicable diseases and infections for 3 of 3 (MA A, CNA B, and CNA C) staff members and 3 of 5 residents (Residents #49, #35, and #15) reviewed for infection control procedures. MA A failed to disinfect the blood pressure cuff in between blood pressure checks for Residents #49 and #35. CNA B and CNA C failed to change their soiled gloves and perform hand hygiene during incontinent care on Resident #15. These failures could place residents at risk for cross contamination and infections.Findings included: Record review of Resident #49's quarterly MDS assessment dated [DATE], revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #49 had diagnoses which include: Hypertension (high blood pressure), cerebral vascular accident (stroke), and constipation (hard stool). Resident #49 was alert and oriented and able to make decisions and required assistance of one staff for activities of daily living. Record review of Resident #49's physician orders dated 04/13/2026 (open ended) reflected, amlodipine (high blood pressure) 50mg give one tab by mouth once a day, and amlodipine Besylate (high blood pressure) 5mg give one tab by mouth two times a day and obtain blood pressure one time a day on each shift. Record review of Resident #35's quarterly MDS assessment dated [DATE], revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #35 had diagnoses which include: Hypertension (high blood pressure), cerebral vascular accident (stroke), non-Alzheimer's dementia (confusion) and constipation (hard stool). Resident #35 had moderate cognitive impairment and was unable to make decisions and required assistance of one staff foractivities of daily living. Record review of Resident #35's physician orders dated 04/02/25 (open ended) reflected, metoprolol (high blood pressure) 75 mg give one tab by mouth two times a day. Obtain blood pressure one time a day on each shift. Record review of Resident #15's quarterly MDS Assessment, dated 01/13/2026, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #15 had diagnoses which included: hypertension (increased blood pressure), and cerebrovascular accident (stroke). Resident #15 was severely cognitively impaired and unable to make decisions for herself and required two staff for assistance with activities of daily living. She was incontinent of bowel and bladder. Observation on 04/14/2026 at 9:48 a.m., revealed MA A performing morning medication pass, during which time she checked the blood pressure on Resident #49. MA A failed to sanitize the blood pressure cuff before or after using it on Resident #49. Observation on 04/14/2026 at 9:58 a.m., revealed MA A performing morning medication pass, during which time she checked the blood pressure, on Resident #35, using the same blood pressure cuff used on Resident #49. MA A failed to sanitize the blood pressure cuff before or after using it on Resident #35. An interview on 04/14/2026 at 10:15 a.m., MA A stated she did not think about cleaning the blood pressure cuff between usage, she did not know she needed to. MA A stated she had used hand sanitizer on her hands between each usage when she took the blood pressure. MA A stated if the cuff was on the residents and then not cleaned it could spread germs to others. MA A stated she had in-service in the past three months concerning infection control and cleaning of equipment and handwashing. MA A stated, I guess I just forgot. Observation on 04/14/2026 at 1:53 p.m. CNA B and CNA C entered the room to transfer Resident #15 back to bed and perform incontinent care and activities of daily living with Resident #15. CNA B and CNA C did not use hand gel in the hallway or wash their hands and donned clean gloves. Resident #15 was transferred from the wheelchair to the bed and was lying on her back in bed. CNA B explained to the resident what she was going to do, and the resident agreed. CNA B removed Resident # 15's pants, leaving on her top. CNA C unfastened the brief tabs and CNA B wiped the pubic area with a disposable wipe, discarded the wipe, in the trashcan, while CNA C held the trashcan over the bed, with no trashcan liner in it. CNA B used another (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wipe on the peri area and discarded it. CNA B repositioned Resident #15 to her right side while pulling the clean brief under the resident. CNA B then used another wipe on the left buttocks, pulling the urine soiled brief off and placing in the trashcan. CNA B repositioned Resident #15 to her left side while pulling the clean brief under the resident. CNA B and CNA C without changing their soiled gloves or washing their hands fastened the tabs of the clean brief, pulled down her shirt, repositioning her on the bed. CNA C and CNA B pulled up Resident #15 in the bed, pulled up the top sheet and blanket, after placing a pillow between the resident's legs. CNA B and CNA C placed their gloves in the trashcan and washed their hands removing the trashcan from the room. An interview on 04/14/2026 at 2:30 p.m. with CNA B and CNA C revealed the CNAs stated, they were supposed to cleanse their hands with hand sanitizer or wash them in between dirty and clean glove changes, but they (CNAs) always have to change this resident at the end of their shift and it gets frustrating for them, they get into a hurry, so they did not change their gloves or clean their hands. Both CNAs stated they had both had in-service in the past three months concerning infection control for handwashing and incontinent care. CNA C stated she was new to the facility and had the training when she was first hired, but she had been a CNA for a long time and just thought the other CNA knew what she was doing so she followed her. An interview with the DON, who was the infection control preventionist on 04/16/26 at 9:33 a.m., revealed the DON stated that all direct care staff must clean equipment, including blood pressure cuffs after having contact with each resident. The DON stated, the staff has available the disinfectant wipes that will kill all germs. The DON stated the staff when performing incontinent care should be changing gloves from dirty to clean and washing their hands or using the available hand sanitizer. The DON stated she and her ADON had just had an in-service on 03/25/2026 concerning all of this, presenting step by step the cleaning of equipment and incontinent care. The DON stated that some of the CNAs had spent extra time with them, to make sure they understood. The DON stated during the in-service the staff did not ask any questions and appeared to understand and indicated they knew everything. The DON stated if they do not clean the blood pressure cuffs appropriately and change gloves and clean their hands when they should, they could spread germs to themselves and the residents. Record review of an in-service log dated 03/25/2026 revealed MA A and CNA B, and CNA C (she had received at hiring) had received cleaning and properly storing equipment after each use and how to perform correct incontinent care. Record review of the Facility's Policy titled Infection Prevention and Control program dated revised October 2022, reflected: Policy: The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. The elements of the infection control prevention and control program consist of coordination/oversight, surveillance, data analysis, antibiotics stewardship, outbreak management, prevention of infection, and employee health and safety. The program will be carried out by the facility infection preventionist. It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers. Goals: decrease the risk of infection to residents and personnel. recognize infection control practices while providing care. Reporting Mechanisms for infection control. 6. c. Effective cleaning and disinfecting equipment as needed .between each residents use. Record review of the Facility's Policy titled Infection control Prevention and Control program-Hand Hygiene undated reflected: This facility considers hand hygiene the primary means to prevent the spread of infections . 4. Use an alcohol-based hand rub or alternative soap and water following. h. before moving from a contaminated body site to a clean body site during resident care: i. after contact with a resident's intact skin. 6. The use of gloves does not replace hand washing/hand hygiene. Record review of the Facility's Policy titled Perineal/Incontinent Care dated December 2024 reflected: Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident to prevent infections and skin irritations, and to observe the resident's skin condition . Steps to procedure 1. Place equipment on bedside . 2. Wash and dry your hands thoroughly . 7. Put on gloves . [steps to perform incontinent care for male/female] . 12. Remove gloves and discard into designated container. Wash and dry hands (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	thoroughly. 13. Replace the bed covers. Make the resident comfortable . 17. Wash and dry hands thoroughly