STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675783	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Mountain View	2918 Duncanville Rd Dallas, TX 75211

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident had the right to personal privacy and confidentiality of his or her personal and medical records for one of 8 residents (Residents #1) reviewed for confidentiality of records. The facility failed to ensure LVN A did not leave the computer tablet on top of a medication cart from disclosing Residents #1's EMAR's insulin administration on 09/05/25 from 11:10 AM to 11:13 AM; Subsequently there was not any staff around the medication cart for approximately three minutes. This failure could place residents at risk of having their medical information disclosed to residents and visitors which could cause embarrassment, frustration, and feelings of decreased privacy, which could result in a decline in health and psycho-social well-being. The findings include: Record review of Resident #1's admission MDS assessment, dated 06/26/25, revealed a [AGE] year-old who was admitted to the facility on [DATE]. Resident #1 had a BIMS score of 15, which indicated no cognitive impairment. He needed setup to partial/moderate assistance with his ADL and with rolling, sit to standing and transfers. Resident #1 had medically complex conditions with diagnoses which included cirrhosis (chronic liver damage), Renal insufficiency (non-functioning liver), viral hepatitis (liver inflammation), DM (diabetes mellitus), asthma (inflammation of airway), respiratory failure (abnormal lung function). For medications Resident #1 had six insulin injections in the past seven days. Record review of Resident #1's Care Plan, date initiated 06/20/25, revealed, Focus - The resident has diabetes mellitus and is currently receiving Insulin Regular Human injection Solution 100 unit/ml. Goal - the resident will have no complications related to diabetes through the review date. Interventions - Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Record review of Resident #1's Order Summary Reported, printed 09/05/25, revealed, a start date of 07/28/25 for Humulin R 100 UNIT/ML Solution Inject as per sliding scale, subcutaneously before meals for diabetes. Record review of Resident #1's September [DATE] revealed On 09/05/25, the hour to administer the diabetic insulin was at 11:30 AM, Humulin R 100 Unit/ML solution, inject as per sliding scale 151-200 = 3 units. LVN A checked his BS (blood sugar) that was 200 and she gave [Resident #1] three (3) units, subcutaneously before meals for diabetes. Observation on 09/05/25 at 11:10 AM revealed an unattended medication cart which was in the doorway of room [ROOM NUMBER], the computer screen displayed a residents picture and administration of a Humulin injection on 09/05/25 at 11:04 AM. The medication cart was positioned in front of Resident #2 and Resident #3's opened room door, while they were lying in bed watching TV. (There was no one around the medication cart and at a distance, several of the staff was seen walking around the nurses station). Observation on 09/05/25 at 11:13 AM, LVN A walked up to the medication cart. Observation and interview on 09/05/25 at 11:14 AM, LVN A saw the HHSC investigator standing by the medication cart and moved the medication cart down the hall then she locked the computer screen. She stated she had just given Resident #1's his diabetic medication and left the medication cart because she was trying to catch the Doctor before he left. When queried about why the computer screen displayed resident information, she responded she had a key, and the computer only showed the resident's name. (After she reviewed a picture of Resident #1's EMAR on the computer screen) she stated nobody should have access to the computer and there were no issues with the residents' information being disclosed to others. She stated it was a HIPAA violation for the resident's information to be displayed on the computer. She stated the plan to prevent this from re-occurring was to ensure she locked the computer before she walked away from it. Interview on 09/05/25 at 4:55 PM, the Administrator (by phone) stated she was not aware of any of the nurses leaving the computer tablets unattended and unlocked today (09/05/25). She stated she could not say how it could affect the residents with unlocked computers displaying resident information. She stated it was against company policy to leave the computer tablets unlocked. She stated their plan to address this was for LVN A to be counseled and written up on HIPAA non-compliance. She stated the DON started the trainings this morning (09/05/25) with all the nurses . Interview on 09/05/25 at 5:24 PM, the DON stated she was aware of LVN A leaving the computer screen unlocked today (09/05/25). She stated LVN A was given a 1:1 training and was written up for leaving her screen unlocked and displaying resident information. She stated what LVN A did was a HIPAA violation and all of the resident's private information could have been disclosed for family or anybody to see. Record review of LVN A's Employee Coaching and Counseling Record, dated 09/05/25, revealed a written warning: time of violation 6 - 2, location 500 hall, type of violation: Major Infraction, Company/Supervisor remarks: It has come

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 6 halls (Hall 500) reviewed for medication storage. The facility failed to ensure LVN A did not leave her medication cart, on the 500 hall, unattended and unlocked at the entrance of Resident #2 and #3's opened room door on 09/05/25 at 11:10 AM. This failure could place residents at risk of having their medications taken or consumed by other residents, which could cause a drug diversion, shortage of medications, change in condition which could result in a decline in health and psycho-social well-being.The findings include: Observation on 09/05/25 at 11:10 AM revealed an unattended medication cart that was in the doorway of room [ROOM NUMBER], and the medication cart's silver lock button was extended out and had a visibly seen red dot on the right side which revealed it was unlocked. The medication cart was positioned in front of Resident #2 and #3's opened room door, as they were lying in bed watching TV. (There was no one around the medication cart and at a distance, several of the staff was seen walking around the nurses station). Observation on 09/05/25 at 11:13 AM, LVN A walked up to the medication cart. Observation and interview on 09/05/25 at 11:14 AM, LVN A saw the HHSC investigator standing by the medication cart and moved the medication cart down the hall then she press in the lock to the medication cart. She stated she had just given Resident #1 his diabetic medication and had left the medication cart because she was trying to catch the Doctor before he left. When queried about why the medication cart was unlocked, she responded she had a key (and she lifted it into the air). She stated anybody could open the medication cart and could have taken the residents medications if the medication cart was unlocked. She stated the medication cart should have been locked. She stated she was not sure how it could affect the residents with having an unlocked medication cart. She stated the plan to prevent this from re-occurring was to lock the medication cart before she walked away from it. Interview on 09/05/25 at 4:55 PM, the Administrator (by phone) stated she was not aware of any of the nurses leaving the medication carts unattended and unlocked today (09/05/25). She stated she could not say how it could affect the residents with unlocked medication carts. She stated it was against company policy to leave the medication carts unlocked. She stated their plan to address the failure was for LVN A to be counseled and written up on making sure the medication carts were locked. She stated the DON started the trainings this morning (09/05/25) with all the nurses. Interview on 09/05/25 at 5:24 PM, the DON stated she was aware of LVN A leaving the medication cart unlocked today (09/05/25). She stated LVN A was given a 1:1 training and wrote her up for leaving her medication cart unlocked. She stated what LVN A did could have resulted in a drug diversion or other residents could have taken medications out of the medication cart. Record review of LVN A's Employee Coaching and Counseling Record, dated 09/05/25, revealed a written warning: time of violation 6 - 2, location 500 hall, type of violation: Major Infraction. Company/Supervisor remarks: It has come to the attention of management that the high standards that [This Company] espouses are not being met. Specifically 1. HIPPA compliance: b leaving resident information visible while unattended 2. Resident medication integrity/resident safety: Leaving medication cart unlocked care [sic]: our residents deserve great care. We want to give you an opportunity to correct this behavior, failure to do so can, and will lead to further disciplinary actions up to and including termination. Signed by LVN A, Supervisor ADON B and witness HR C with signatures dated 09/05/25. Record review of the Facility's Storage of Medications Policy, dated April 2007, revealed Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation - 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.