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	12/10/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview, observation, and record review, the facility failed to provide a safe, clean, and comfortable environment for residents on 5 (halls 100, 200, 400, 500 and 600) of 6 halls reviewed. The facility failed to provide a comfortable environment on 12/09/25 when the surveyor observed CNA C spraying a strong scented perfume down the 200 hall. The facility failed to provide a clean and comfortable environment on 12/09/25 when the surveyor observed 2 32-gallon trash bins on the 100, 200, 400, 500 and 600 hall. The facility failed to provide a safe environment on 12/09/25 when the surveyor observed unlocked mechanical lift were observed unlocked on halls 100 and 200. The facility failed to provide a safe environment on 12/10/25 when the surveyor observed an unlocked mechanical lift and shower bed on the 100 hall and an unlocked mechanical lift on the 200 hall. These failures could place residents at risk of an unsafe and diminished quality of life. Findings included:During an observation on 12/09/25 at 10:15 a.m., 32-gallon trash bins with an odor of urine and feces that could be smelled down hall 200,2 32 - gallon trash bins were observed on 100, 200, 400, 500 halls. mechanical lifts were observed unlocked on halls 100 and 200.During an observation on 12/09/25 at 10:50 a.m., CNA C was observed spraying a strong perfume down the hall 200 and no residents were observed in the hallway at that time.During an interview on 12/09/25 at 11:00 a.m., the Treatment Nurse stated the spray could affect residents with respiratory concern/issues and could cause an adverse reaction. The Treatment Nurse stated she would notify the DON so that staff could be in-serviced.During an interview on 12/09/25 at 11:30 a.m., LVN D stated sometimes the residents complained of the smell of urine and feces. LVN D stated CNA C sprayed the perfume close to the ground to prevent it from affecting residents with respiratory issues.During an interview on 12/09/25 at 1:19 p.m., CNA C stated she sprayed the perfume low to the ground because the hallway was smelly, and residents complained about the smell.During an interview on 12/09/25 at 2:10 pm, CNA F stated she brought Febreze to spray instead of perfume to help with the odor.During an interview on 12/09/25 at 2:40 p.m., the Admin stated the Hoyer lift could not be locked because life safety told her that the equipment had to be movable. The Admin stated the equipment on the Egress pathway could not be locked.During an observation on 12/10/25 at 5:15 a.m., the surveyor observed an unlocked mechanical lift and shower bed on the 100 hall and an unlocked mechanical lift on the 200 hall.During an observation and interview on 12/10/25 at 6:30 a.m. , the ADON moved the mechanical lift and the shower bed out of the hallway. The ADON stated he moved the equipment to prevent residents from falling and removed the equipment from the floor.During an interview on 12/10/25 at 1:10 p.m., the Admin stated equipment in the hallway had to be left unlocked because of the egress pathway and she was going by what Life Safety told her.Record review of email to surveyor from Life Safety Director on 12/10/25 at 11:21 a.m. reflected, [LS] does not tell anyone not to lock Hoyer lifts [mechanical lift]. They cannot store Hoyer lifts [mechanical lift] in the corridors.Record review of email to LS from surveyor on 12/10/25 3:25 p.m. reflected if Hoyer lifts are on an egress pathway does that mean they can't be locked?Record review of LS email to surveyor reflected on 12/10/25 at 3:30 p.m. It has nothing to do with being locked or unlocked. They cannot store them in the path of egress.Record review of the facility policy Hazardous area, devices and Equipment, dated 07/2017 reflected, A hazard is defined as anything in the environment that has the potential to cause injuryor illness. Examples of environmental hazards include, but are not limited to the following: Openareas or items that should be locked when not in use;. Assessment and analysis of hazards. 2.Any element of the resident environment that has the potential to cause injury and that is accessible to a vulnerable resident is considered hazardous.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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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 0880 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 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 infection for 1 (Resident #1) of 5 residents reviewed for infection control. -The facility failed on 12/09/25 to ensure infection control procedures were followed when LVN F repositioned Resident #1, who was on enhanced barrier precautions, without donning appropriate PPE. -The facility failed on 12/10/25 to ensure infection control procedures were followed when CNA A and CNA B handled soiled linen and provided perineal care to Resident #1, who was on enhanced barrier precautions, without donning appropriate PPE. -The facility failed on 12/10/25 to ensure infection control procedures were followed when LVN B provided G-tube care to Resident #1, who was on enhanced barrier precautions, without donning appropriate PPE. This failure could place residents at risk of infection. Findings included:Record review of Resident #1's face sheet, dated 12/10/25 reflected he was a [AGE] year-old male who was admitted on [DATE] and diagnosed with cerebral infraction (type of stroke that occurs when a blood vessel in the brain is blocked, causing damage to brain tissue), hemiplegia following cerebral infraction right dominant side (Complete paralysis to one entire side of the body), Alzheimer's disease (the most common form of dementia, affecting memory, thinking, and behavior. It is characterized by the buildup of proteins in the brain, leading to the death of brain cells and gradual decline in cognitive function), and gastrotomy status (Refer to the condition of a patient who has undergone a gastrostomy procedure, which involves creating an opening into the stomach for feeding or drainage purposes).Record review of Resident #1's MDS, dated [DATE] reflected, his BIMS score was 03 which indicated severe cognitive impairment. Resident#1 always had urinary and bowel incontinent, Resident#1 was classified as dependent, which meant Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the residents to complete the activity for toileting hygiene, shower/bathe, lower body dressing, roll left and right, sit to lying, lying to sitting on side of bed.Record review of Resident #1's care plan, undated, reflected Resident#1 required tube feeding (PEG-TUBE) r/t GI complications. [Resident#1] goal reflected [Resident#1] will remain free of side effects or complications related to tube feeding through review date. Resident#1 Interventions did not include EBP.Record review of Resident #1's order, dated 10/15/25 reflected Enhanced Barrier Precautions r/t G-TUBE every shift Follow Facility Policy - **USE for patients with any of the following (when Contact Precautions do not otherwise apply): Wounds or indwelling medical devices, regardless of MDRO colonization status Infection or colonization with an MDRO**During an interview on 12/09/25 at 11:00 a.m., the wound care nurse stated residents who were on EBP precautions required staff to wear gown and gloves when high contact care was provided. The wound care nurse stated residents on EBP had a sign above each of their beds.During an interview and observation on 12/09/25 at 11:35 am, surveyor observed LVN F reposition Resident#1 in bed without putting on gown and gloves. Surveyor observed LVN F use hand sanitizer when she returned to the medication cart. LVN F stated a gown and gloves needed to be worn when peri care was provided to Resident#1. During an observation on 12/10/25 at 5:15 a.m., observed CNA A pick linens off the floor from Resident #1's side of the room with no gown on and carried the linens in her hand out of the room. Observed CNA A and CNA B provide peri care to Resident #1 (Surveyor stood out of view of Resident #1's private areas). Surveyor observed CNA A and CNA B not wearing PPE gown. LVN B entered the room and detached Resident #1's G-Tube from his port with no PPE gown on. LVN B walked out of the room with tubing and empty formula bottle. Observed CNA A walked out of the room with trash bags and gloves. Surveyor did not observe CNA A wash hands or use hand sanitizer after she disposed the trash. Observed CNA B, removed gloves and washed her hands before she exited the room. During an interview on 12/10/25 at 5:30 a.m., CNA A and CNA B stated residents with wounds, catheter and G-Tubes were supposed to wear gowns and gloves when direct care was provided. CNA A and CNA B stepped back in Resident #1's room and stated the enhanced barrier sign was posted above his bed. CNA A and CNA B both stated infections could be spread from resident to resident by not wearing the PPE. CNA A and CNA B stated hands should be washed before and after providing care to residents. Record review of matrix-802 and observations of resident's rooms with EBP signs above bed from 12/09/25 to 12/10/25 reflected 23 residents were on enhanced barrier precautions. During an over the phone interview at 1:20 pm, the Medical Director stated staff should wear gown and