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	04/14/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and failed to care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for 1 (Resident #1) of 5 residents reviewed for dignity. The facility failed to ensure the door or curtain was closed for Resident #1 while she was asleep in Bed A in her underwear. These failures placed the resident at risk of not having her right to a dignified existence maintained.Findings included: Record review of Resident #1's Face Sheet, dated 04/14/26, reflected an [AGE] year-old female admitted on [DATE], with an initial admission date of 02/25/26. Resident #1 had diagnoses that included dementia (loss of memory, language, problem-solving, and thinking abilities), lack of coordination, muscle wasting and atrophy (loss of muscle mass), muscle weakness, and abnormalities of gait and mobility (limping, shuffling, or imbalance). Record review of Resident #1's Quarterly MDS Assessment, dated 03/02/26, reflected a BIMS score of 6, which indicated severe cognitive impairment. The Quarterly MDS Assessment indicated Resident #1 was dependent on staff for dressing. The Quarterly MDS Assessment indicated Resident #1 is dependent on staff for lower body dressing. The MDS Assessment also indicated Resident #1 was impaired on both sides of her lower extremity. Record review of Resident #1's Comprehensive Care Plan, undated, did not reflect the resident would undress. Observation on 04/14/26 at 10:46 AM reflected Resident #1 was asleep in Bed A in her underwear with the door open. In an interview on 04/14/26 at 1:37 PM, Resident #1 stated she did not remember that she did not have on pants earlier. In an interview on 04/14/26 at 1:39 PM, Resident #2 stated her roommate would get hot and take her pants off. Resident #2 stated Resident #1 had taken her pants off the night before and did not put them back on until the next morning. Resident #2 stated she told Resident #1 she needed to take off some of those clothes when she's hot. Resident #2 stated staff typically closed the curtain or closed the door when Resident #1 was in her underwear. In an interview on 04/14/26 at 1:44 PM, LVN A stated Resident #1 was confused and did not typically keep her pants on. LVN A stated staff typically closed the door after coming out of the room. LVN A stated staff had taken Resident #1's pants off for her when she needed to go to the restroom. LVN A stated it was not okay for the resident to lie in bed in her underwear with the door open. LVN A stated she had tried to keep the resident's door closed multiple times, but Resident #1 would get back up and open the door. LVN A stated she had tried closing the door, closing the curtain, and putting clothes on Resident #1. LVN A stated the risk of Resident #1 lying in bed in her underwear was that she did not have privacy. In an interview on 04/14/26 at 2:38 PM, CNA B stated it was not okay for Resident #1 to lie in bed in her underwear with the door open. CNA B stated the risk of Resident #1 being exposed in her underwear was that a male resident walking down the hallway could see her.In an interview on 04/14/26 at 3:08 PM, CNA C stated Resident #1 would get hot and take off her pants, leaving her in her underwear. CNA C stated Resident #1 would take off her clothes. CNA C stated Resident #1 would also be dressed in a gown and then take that off when she became hot. CNA C stated Resident #1's roommate controlled the air on her side of the room. CNA C stated she typically went into the room to (continued on next page)

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
	675783	A. Building B. Wing	04/14/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ask Resident #2 to adjust the room temperature because Resident #1 was hot. CNA C stated Resident #2 would tell Resident #1 that she needed to take some of those clothes off when Resident #1 complained about being hot. CNA C stated the risk of Resident #1 lying in bed in her underwear and being exposed was that she lacked privacy. In an interview on 04/14/26 at 3:32 PM, the ADON stated today was his first time he had walked down the hallway at the wrong time and noticed Resident #1 putting a shirt on with the door open. The ADON stated he then asked a nurse whether that was something Resident #1 did on a regular basis. The ADON stated the facility would move forward by possibly putting Resident #1 in a B-bed or coming up with another solution to provide Resident #1 more privacy. When asked whether this behavior should have been in Resident #1's care plan, the ADON stated if that was Resident #1's behavior, it should have been included in the care plan. The ADON stated Resident #1 seemed as if she did not want the door closed. The ADON stated the risk of Resident #1 being in her underwear with the door open was exposure. In an interview on 04/14/26 at 4:22 PM, the Administrator stated staff were expected to protect residents and maintain their dignity. The Administrator stated Resident #1 had not been doing that before and believed it was a new behavior. The Administrator stated staff tried to give Resident #1 privacy as best they could. The Administrator stated that when Resident #1 was on the 400 hallway, she had never noticed the resident to be undressed with the door open. The Administrator stated staff were then updating the resident's care plan. The Administrator stated the risk of Resident #1 being in her underwear was a dignity issue and a resident rights concern. Record Review of the facility's policy titled Promoting/Maintaining Resident Dignity, dated 10/01/25, reflected in part: Policy- It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance Guidelines: 1.All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.2.During interactions with residents, staff must report, document and act upon information regarding resident preferences.