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	05/15/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24-hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials (which included the State Survey Agency and Adult Protective Services where state law provides for jurisdiction in long-term care facilities) in accordance with State Law through established procedures for 1 of 3 residents (Resident #154) reviewed for abuse and neglect. The facility failed to report to HHSC when Resident #154 was found to have eloped from the facility on 04/19/24. This failure to report could place the residents at risk for neglect. Findings included: Review of Resident #154's Face Sheet, dated 05/13/25, reflected he was an [AGE] year-old male who admitted to the facility on [DATE] and discharged on 11/20/24. Review of Resident #154's Quarterly MDS Assessment, dated 02/28/24, reflected he had a BIMS score of 04, indicating severe cognitive impairment. His MDS indicated he did not have any behaviors of wandering and that he utilized a wheelchair to ambulate. His active diagnoses included depression (feelings of severe despondency and dejection) and bipolar disorder (a mental health condition characterized by significant mood swings). Review of Resident #154's Care Plan, dated 05/14/25, reflected the following: Problems: [Resident #154] is at risk for wandering as evidenced by: Dementia/Alzheimer's .Interventions: Observe location each shift and prn .Report any attempts to exit the facility to IDT, family & MD as indicated and record in the clinical record .Place a wanderguard bracelet on [Resident #154] if attempt to leave out the facility [sic] .[Resident #154] requires a Wander Guard Bracelet [sic] and is at risk for injury from wandering in an un-safe enviornment [sic] .Interventions: Monitor for placement q shift, monitor for proper functioning q 24 hours . (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	05/15/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #154's Elopement Risk Assessment, dated 11/01/24, reflected the following: 1. NO RISK, B) Patient is unable to ambulate or mobilize wheelchairs .2. MODERATE RISK, A) Patient is cognitively impaired AND .3. IMMINENT RISK, ACTION: Implement Elopement Risk Care Plan .Comments: Shows no signs of elopement. Review of Resident #154's Elopement Risk Assessment, dated 06/27/24, reflected the following: 1. NO RISK, B) Patient is unable to ambulate or mobilize wheelchairs .2. MODERATE RISK .3. IMMINENT RISK, ACTION: Implement Elopement Risk Care Plan . Review of Resident #154's electronic health chart revealed there were not any other elopement risk assessments completed. Review of Resident #154's Clinical Notes Report reflected the following: - pt left the facility and was on the street on his own. A staff member brought the patient back in the facility and when asked why the patient went to the road, pt replied meeting my wife at the gas station. She is getting me some coffee'. [sic] pt was told by the RN that his wife is not in the gas station. pt had a skin tear on his left arm. the skin tear was cleansed, and bacterial ointment was applied and then it was covered with kerlix written on 04/19/24 at 9:24 PM by RN G - At this time resident remains in bed, no s/s of pain and or discomfort noted. Resident noted to be resting on and off, but resident remains in bed and no attempts to get out of bed or facility noted at this time. All safety measures met. Written on 04/20/24 at 12:33 AM by LVN H - Resident was brought to nurses station by reception informed [sic] that resident pushed door open trying to go outside call [sic] placed to [the NP]. Notified of resident attempt to go out of front door [sic]. N/O may apply Wander guard for safety. Call to [Resident #154's Family Member] at [phone number] notified of attempt to go out of front door will be [sic] placing a wander guard to lower extremity. foe [sic] safety reason. stated'thank You' [sic] written by LVN I on 07/26/24 at 11:39 AM. Review of an Accident/Incident Report, dated 04/19/24, reflected the following : Person in charge- account of occurrence: pt left the facility was on the street on his own. A staff member brought the patient back in the facility and when asked why the patient went to the road, pt replied meeting my wife at the gas station. she is getting me some coffee'. pt was told by the RN that his wife is not in the gas station. pt had a skin tear on his left arm. the skin tear was cleansed, and bacterial ointment was applied and then it was covered with kerlix. Completed by RN G. Review of the Texas Unified Licensure Information Portal revealed there was no incident report regarding Resident #154's elopement on 04/19/24 indicating the facility never reported it. (continued on next page)

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	05/15/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on the phone on 05/12/25 at 10:53 AM with Resident #154's Family Member revealed Resident #154 left the facility in November 2024. Resident #154's Family Member said Resident #154 used a wander guard bracelet while at the facility which she said was not necessary because the resident as far as she knew never tried leaving or left the facility. Interview on the phone on 05/13/25 at 2:06 PM with RN G revealed, she no longer worked at the facility and could not remember the incident from April 2024. Interview on the phone on 05/13/25 at 2:24 PM with CNA J was unsuccessful as she did not answer. CNA J was working on 04/19/24 and was assigned to Resident #154. Interview on 05/13/25 at 2:30 PM with RA K revealed she was not here when Resident #154 eloped from the facility on 04/19/24 but she heard he had left through the back door of the facility near where the dumpsters were at. RA K said Resident #154 had a wander guard placed on his leg after this incident happened. Interview on 05/14/25 at 11:45 AM with LVN H revealed she could not recall anything about Resident #154's elopement on 04/19/24. Interview on 05/14/25 at 3:15 PM with the DON revealed she was in training in April 2024 when Resident #154 eloped from the facility so she did not have any details about it. The DON said after reading the incident report, the elopement should have been reported to the state. Interview on the phone on 05/15/25 at 9:20 AM with the Previous Administrator was unsuccessful as she did not answer. Interview on the phone on 05/15/25 at 9:21 AM with the Previous DON was unsuccessful as he did not answer. Interview on 05/15/25 at 10:10 AM with the Administrator revealed she was not yet employed by the facility on 04/19/24 when Resident #154 eloped from the facility. The Administrator said she was not informed about the elopement either when she arrived to the facility. The Administrator said since she was not at the facility on 04/19/24 she had no details about what happened. The Administrator said she expected staff to report when a resident eloped from the facility. The Administrator said she was not sure if this incident was reportable or not because she would have to review the criteria and guidelines to see if it met the requirements to be reported. The Administrator said currently she was the Abuse Coordinator for the facility and would help to determine if something was reportable or not. The Administrator said at the time of the incident, the Previous Administrator or their designee would have been responsible for reporting the incident involving Resident #154's elopement on 04/19/24. The Administrator said all staff had been trained to know the facility's abuse/neglect policy. The Administrator said if the facility failed to report they would be cited for that. The Administrator said she rounds frequently with staff to ensure they were reporting necessary things to her. Review of an in-service roster, dated 11/01/24, and titled Staff in-services initiated the following: abuse prevention policy .Timely Reporting/Recognizing Abuse , Neglect [sic] and Misappropriation . reflected 108 staff's signatures. (continued on next page)

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	05/15/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy, dated January 2024, and titled Elopement Response Protocol reflected: .9. Notify the state regulatory department according to the guidelines for reportable incidents. Review of the facility's policy, dated April 2019, and titled Abuse Protocol reflected: .7. The following definitions are provided to assist our Facility's [sic] staff members in recognizing incidents of Patient Abuse [sic]: i. Adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof .l. Neglect is the facility, it's employees or service providers to provide goods and services to a Patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .10. The Abuse Prevention Coordinator will: a Immediately (within 2 hours) report to The Department of Aging and Disability Services (DADS) and other appropriate authorities incidents of Patient Abuse [sic] as required under applicable regulations and regulatory guidance. Report events that cause reasonable suspicion of serious bodily injury immediately (within 2 hours) after forming the suspicion to The Department of Aging and Disability Services (DADS) and other appropriate authorities as required under applicable regulations and regulatory guidance.

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	05/15/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate assessments with the PASRR program for 1 of 5 residents (Resident #66) reviewed for PASRR assessments. The facility did not refer Resident #66 to the appropriate state-designated mental health authority for review when he received a new diagnosis of schizoaffective disorder, bipolar type. This failure could place residents at risk of not being evaluated and receive needed PASRR services. Findings included: Record review of Resident #66's face sheet dated 05/15/25 reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. Resident #66 was diagnosed with schizoaffective disorder, bipolar type on 04/14/25. Record review of Resident #66's MDS Assessment, dated 03/21/25, reflected the resident had an active diagnosis of depression disorder, anxiety disorder, psychotic disorder, non-Alzheimer's dementia and the resident had severe cognitive impairment with a BIMS score of 05. Record review of Resident #66's Care plan reflected [Resident #66] currently taking psychotropic medication(s) as evidenced by: Major Depressive Disorder, Anxiety/Panic Disorder, psychosis. Goals: [Resident #66] will not experience adverse side effects over the next 90 days. Interventions: Monitor and record any displayed behavior or mood problems. Record review of Resident #66's PASRR Level 1 Screening, dated 11/16/21, reflected he did not have a mental illness. PASRR Level 1 screening did not indicate Resident #66 had primary diagnosis of dementia. Record review of Resident #66's, 1012 Form (Mental Illness/Dementia Resident Review) dated 11/22/23 reflected: the individual has a primary diagnosis of dementia as define above. The physician signs and dates the form attesting to the dementia diagnosis. Complete Section D and E of the form. -Section D and Section E not completed. Interview on 05/15/25 at 2:21 PM, RCC stated Resident #66 had a negative PASRR Level 1. She stated Resident #66 had a primary diagnosis of Dementia. The RCC reviewed Resident #66's medical chart and stated Resident #66 did not have any documentation stating he had a diagnosis of Dementia other than the psych notes. RCC stated Resident #66 had a 1012 form completed on 11/22/23 and stated Resident #66's primary diagnosis was dementia. The RCC stated since the 1012 Form stated a primary diagnosis of dementia it would override any new diagnosis. Interview on 05/15/25 at 3:39 PM, the DON stated if a new diagnosis was given to a resident a new PASRR evaluation should be completed. The DON stated to ask RCC for any questions regarding Resident #66's PASRR. (continued on next page)

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	05/15/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Follow up interview on 05/15/25 at 4:03 PM, the RCC stated Resident #66's, 1012 Form was not completed correctly. She stated since given a new diagnosis and new 1012 form or PASRR Level 1 should had been completed. She stated the potential risk would be resident being positive for PASRR and would be missing out on PASRR services. Record review of facility admission Criteria policy, undated, reflected the following: 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process.

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	05/15/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and psychosocial needs that are identified in the comprehensive assessment that describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 8 residents (Resident #22) reviewed for care plan accuracy. The facility failed to develop a care plan with measurable objectives and timeframes to address Resident #22's care needs. This failure could place residents at risk of receiving inadequate interventions not individualized to their care needs. Findings included: Record review of Resident #22's admission Record, dated 05/15/25, reflected she was a [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #22's admission MDS Assessment, dated 04/16/25, reflected the resident had an active diagnosis of chronic obstructive pulmonary disease, heart failure, hypertension (high blood pressure), diabetes mellitus (inadequate control of blood levels of glucose), muscle weakness, and septicemia (infection where bacteria enter the bloodstream and spread throughout the body). Resident #22 had a BIMS score of 14, indicating cognitively intact. It also indicated she was being administered an antidepressant, antibiotic, diuretic, hypoglycemic and opioid medications. The MDS Assessment also indicated Resident #22 required substantial/maximal assistance with ADL care. Record review of Resident #22's Care plan, dated 05/01/25, reflected the following: Focus: Resident request Code Status of: Full Code. Goal: Status will be maintained over next review period. Interventions: Inform staff of code status. Monitor for decrease in change of condition-report to MD and responsible party. Focus: The resident is risk for falls r/t Gait/balance problems, Incontinence. Goal: The resident will not experience falls or injuries from falls through the review date. The resident will not sustain serious injury through the review date. Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c. Follow facility fall protocol. Focus: The resident has Diabetes Mellitus and is currently receiving [Specify Meds]. No goal or interventions. Care Plan did not address Resident #22 use of antidepressant medication, use of opioids, use of insulin or ADL care. (continued on next page)

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	05/15/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #22's physician orders indicated the following medications being administered: Insulin Lispro 100 UNIT/ML Solution Inject as per sliding scale: if 250 - 300 = 1 Unit; 301 - 350 = 2 Units; 351 - 400 = 3 Units BS greater than 400 mg/dL, notify MD, subcutaneously at bedtime for DM. -Start Date- 04/12/2025. Gabarone Oral Tablet 400 MG (Gabapentin) Give 1 tablet by mouth three times a day for joint pain -Start Date- 04/12/2025. traZODone HCl Oral Tablet 150 MG (Trazodone HCl) Give 1 tablet by mouth at bedtime for insomnia - Start Date- 04/12/2025. Sertraline HCl Oral Tablet 100 MG (Sertraline HCl) Give 1 tablet by mouth one time a day for depression -Start Date- 04/12/2025. Anti-Depressant SE Monitoring: Observe closely for significant side effects of Anti-Depressant medication including drowsiness, blurred vision, dizziness, nausea, fatigue, trouble sleeping, dry mouth, hallucinations, other unusual changes in mood or behavior every shift Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings. -Start Date- 04/15/2025 Torsemide Oral Tablet 100 MG (Torsemide) Give 1 tablet by mouth two times a day for diuretic -Start Date- 05/06/2025. Lantus Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 10 unit subcutaneously at bedtime related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS. Call MD if blood sugar greater than 400 -Start Date- 05/06/2025. Interview on 05/15/25 at 1:57 PM, ADON F revealed she was the ADON assigned to Resident #22. She stated ADONs and DON were responsible for completing care plans. She stated she was responsible for ensuring Resident #22's care plan was completed and accurate. ADON F stated Resident #22's use of an antidepressant, opioids, insulin, ADL care should be addressed on her care plan. ADON F reviewed Resident #22's care plan and stated it was started but not completed. She stated she was not sure why it was not completed. She stated anything that was triggered on the residents MDS Assessment should be care planned. ADON F stated care plans were needed for staff to know what the residents required. Interview on 05/15/25 at 3:00 PM, the DON revealed the IDR team was responsible for completing care plans. She stated the facility MDS Coordinator was on leave and the ADONs were responsible for completing care plans and Regional MDS Coordinator would review and request any additional items needed to be included. The DON stated Regional MDS Coordinator oversees the residents care plans. The DON stated the risk of care plans not being completed could lead staff not providing residents with the care that they supposed to get. Record review of facility Care Plans - Comprehensive policy, revised date 09/2010, reflected the following: (continued on next page)

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	05/15/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident medical, mental and psychological needs in developed for each resident. . 2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. . 7. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment (MDS).

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	05/15/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #154) reviewed for elopements. The facility failed to ensure Resident #154 did not elope from the facility's back door on 04/19/24. Resident #154 was found on the street attempting to go to the gas station across the street from the facility that was located directly off a busy highway. Resident #154 had suffered a skin tear to his arm . The noncompliance was identified as past noncompliance. The IJ began on 04/19/24 and ended on 11/01/24. The facility had corrected the noncompliance before the survey began. This failure could placed residents at risk of serious injury or death. Findings included: Review of Resident #154's Face Sheet, dated 05/13/25, reflected he was a [AGE] year-old male who admitted to the facility on [DATE] and discharged on 11/20/24. Review of Resident #154's Quarterly MDS Assessment, dated 02/28/24, reflected he had a BIMS score of 04, indicating severe cognitive impairment. His MDS indicated he did not have any behaviors of wandering and that he utilized a wheelchair to ambulate. His active diagnoses included depression (feelings of severe despondency and dejection) and bipolar disorder (a mental health condition characterized by significant mood swings). Review of Resident #154's Care Plan, dated 05/14/25, reflected the following: Problems: [Resident #154] is at risk for wandering as evidenced by: Dementia/Alzheimer's .Interventions: Observe location each shift and prn .Report any attempts to exit the facility to IDT, family & MD as indicated and record in the clinical record .Place a wanderguard bracelet on [Resident #154] if attempt to leave out the facility [sic] .[Resident #154] requires a Wander Guard Bracelet [sic] and is at risk for injury from wandering in an un-safe enviornment [sic] .Interventions: Monitor for placement q shift, monitor for proper functioning q 24 hours . Review of Resident #154's Elopement Risk Assessment, dated 11/01/24, reflected the following : 1. NO RISK, B) Patient is unable to ambulate or mobilize wheelchairs .2. MODERATE RISK, A) Patient is cognitively impaired AND .3. IMMINENT RISK, ACTION: Implement Elopement Risk Care Plan .Comments: Shows no signs of elopement. Review of Resident #154's Elopement Risk Assessment, dated 06/27/24, reflected the following: 1. NO RISK, B) Patient is unable to ambulate or mobilize wheelchairs .2. MODERATE RISK .3. IMMINENT RISK, ACTION: Implement Elopement Risk Care Plan . (continued on next page)

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	05/15/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #154's electronic health chart revealed there were not any other elopement risk assessments completed. Review of Resident #154's Clinical Notes Report reflected the following: - pt left the facility and was on the street on his own. A staff member brought the patient back in the facility and when asked why the patient went to the road, pt replied meeting my wife at the gas station. She is getting me some coffee'. [sic] pt was told by the RN that his wife is not in the gas station. pt had a skin tear on his left arm. the skin tear was cleansed, and bacterial ointment was applied and then it was covered with kerlix written on 04/19/24 at 9:24 PM by RN G - At this time resident remains in bed, no s/s of pain and or discomfort noted. Resident noted to be resting on and off, but resident remains in bed and no attempts to get out of bed or facility noted at this time. All safety measures met. Written on 04/20/24 at 12:33 AM by LVN H - Resident was brought to nurses station by reception informed [sic] that resident pushed door open trying to go outside call [sic] placed to [the NP]. Notified of resident attempt to go out of front door [sic]. N/O may apply Wander guard for safety. Call to [Resident #154's Family Member] at [phone number] notified of attempt to go out of front door will be [sic] placing a wander guard to lower extremity. foe [sic] safety reason. stated'thank You' [sic] written by LVN I on 07/26/24 at 11:39 AM. Review of an Accident/Incident Report, dated 04/19/24, reflected the following: Person in charge- account of occurrence: pt left the facility was on the street on his own. A staff member brought the patient back in the facility and when asked why the patient went to the road, pt replied meeting my wife at the gas station. she is getting me some coffee'. pt was told by the RN that his wife is not in the gas station. pt had a skin tear on his left arm. the skin tear was cleansed, and bacterial ointment was applied and then it was covered with kerlix. Completed by RN G . Interview on the phone on 05/12/25 at 10:53 AM with Resident #154's Family Member revealed Resident #154 left the facility in November 2024. Resident #154's Family Member said Resident #154 used a wanderguard bracelet while at the facility which she said was not necessary because the resident as far as she knew he never tried leaving or left the facility. Interview on the phone on 05/13/25 at 2:06 PM with RN G revealed she no longer worked at the facility and could not remember the incident from April 2024. Interview on the phone on 05/13/25 at 2:24 PM with CNA J was unsuccessful as she did not answer. CNA J was working on 04/19/24 and was assigned to Resident #154. (continued on next page)

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	05/15/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 05/13/25 at 2:30 PM with RA K revealed she was not here when Resident #154 eloped from the facility on 04/19/24 but she heard he had left through the back door of the facility near where the dumpsters were at. RA K said Resident #154 had a wander guard placed on his leg after this incident happened. RA K said when a resident had a wander guard on, if they went near a door the alarm would sound off and staff would have to go to redirect them away from the door and reset the code to turn the alarm off. RA K said she was in-serviced regarding elopements and wandering residents. RA K said she knew to immediately report to the nurse if she noticed a resident began to wander or make an attempt to elope from the facility. RA K said she knew the code for an elopement or missing resident was white and required a search of the facility and the grounds to try and find the resident. Interview on 05/14/25 at 8:50 AM with LVN I revealed she cared for Resident #154 but had no idea about his elopement on 04/19/24. LVN I said she remembered Resident #154 had a wander guard bracelet because he had a tendency to wander around the facility. LVN I said if a resident began to have wandering or elopement behaviors it should be reported to her so that she may complete an elopement assessment on the resident. LVN I said she currently had residents who used a wander guard bracelet because they were at risk of wandering or eloping. LVN I said as the nurse she checks those identified resident's wander guard bracelets every shift for placement and functioning. LVN I said when a resident had a wander guard on, if they went near a door the alarm would sound off and staff would have to go to redirect them away from the door and reset the code to turn the alarm off. LVN I said she was in-serviced regarding elopements and wandering residents. LVN I said she knew the code for an elopement or missing resident was white and required a search of the facility and the grounds to try and find the resident. Interview on 05/14/25 at 11:45 AM with LVN H revealed she could not recall anything about Resident #154's elopement on 04/19/24. LVN H said if a resident began to have wandering or elopement behaviors it should be reported to her so that she may complete an elopement assessment on the resident. LVN H said she did not currently have residents who used a wander guard bracelet because they were at risk of wandering or eloping. LVN H if she did care for a resident who used a wander guard bracelet, as the nurse she would check them every shift for placement and functioning. LVN H said when a resident had a wander guard on, if they went near a door the alarm would sound off and staff would have to go to redirect them away from the door and reset the code to turn the alarm off. LVN H said she was in-serviced regarding elopements and wandering residents. LVN H said she knew the code for an elopement or missing resident was white and required a search of the facility and the grounds to try and find the resident. Interview on 05/14/25 at 1:07 PM with CNA L revealed he did not know about Resident #154 elopement from the facility on 04/19/24. CNA L said when a resident had a wander guard on, if they went near a door the alarm would sound off and staff would have to go to redirect them away from the door and reset the code to turn the alarm off. CNA L said he was in-serviced regarding elopements and wandering residents. CNA L said he knew to immediately report to the nurse if he noticed a resident began to wander or make an attempt to elope from the facility. CNA L said he knew the code for an elopement or missing resident was white and required a search of the facility and the grounds to try and find the resident. (continued on next page)

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	05/15/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 05/14/25 at 1:18 PM with CNA M revealed she had only been at the facility for four weeks. CNA M said when a resident had a wander guard on, if they went near a door the alarm would sound off and staff would have to go to redirect them away from the door and reset the code to turn the alarm off. CNA M said she was in-serviced regarding elopements and wandering residents. CNA M said she knew to immediately report to the nurse if she noticed a resident began to wander or make an attempt to elope from the facility. CNA M said she knew the code for an elopement or missing resident was white and required a search of the facility and the grounds to try and find the resident. Interview on 05/14/25 at 3:15 PM with the DON revealed she was in training in April 2024 when Resident #154 eloped from the facility so she did not have any details about it. The DON said she recalled when they had to put a wander guard bracelet on Resident #154 because he would stand up and try to walk towards the doors and set the alarms off to the doors. The DON said with the wander guard bracelet, if Resident #154 got too close to the door the door alarm and the wander guard alarm would both go off and scare Resident #154 so he would back away from it after that. The DON said Resident #154 was easily redirectable but was exit seeking while he tried to find his family. The DON said Resident #154's family was not happy with him having the wander guard bracelet and did not believe the resident required one. The DON said when a resident eloped from the facility she expected staff to get them back inside right away and report to the Administrator and her about what happened. The DON said when the elopement code was activated she also expected her staff to do a sweep of the facility to ensure all residents were in house and safe. The DON said after the resident was safe the facility would investigate to see how they eloped from the facility and that would be corrected. The DON said staff should know to be supervising residents and watching them to make sure they did not leave and if they heard an alarm going off they should make sure they are responding to them. The DON said a number of things could happen to a resident if they eloped from the facility, depending on the weather it could be too cold or hot so they could die, or be hit by a car since there's a busy street behind the facility. The DON said staff were trained and in-serviced regarding resident elopements recently. The DON said when a resident was admitted and had elopement or wandering behaviors the facility would complete an elopement assessment on them and if a wander guard bracelet was necessary to keep them safe one would be placed. The DON said all staff knew to immediately report any new behaviors of a resident wandering or making elopement attempts. Interview on the phone on 05/15/25 at 9:20 AM with the Previous Administrator was unsuccessful as she did not answer. Interview on the phone on 05/15/25 at 9:21 AM with the Previous DON was unsuccessful as he did not answer. (continued on next page)

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	05/15/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 05/15/25 at 10:10 AM with the Administrator revealed she was not yet employed by the facility on 04/19/24 when Resident #154 eloped from the facility. The Administrator said she was not informed about the elopement either when she arrived to the facility. The Administrator said since she was not at the facility on 04/19/24 she had no details about what happened. The Administrator said Resident #154 had tendencies to wander and exit seek and his family was upset about him having to wear a wander guard bracelet. The Administrator said Resident #154 was always at the doors of the facility trying to leave. The Administrator said Resident #154 was always setting off the door alarms and the wander guard system alarms. The Administrator said Resident #154 was easily redirectable away from the doors, however. The Administrator said Resident #154 should not have been able to elope from the facility back in April 2024. The Administrator said she expected all staff to frequently monitor all residents who were at risk of eloping/wandering and to ensure they each were inside and safely in the facility. The Administrator said if a resident had been identified as being at risk of eloping/wandering a wander guard bracelet was placed on them. The Administrator said each resident's nurse would be responsible for checking the wander guard bracelet's placement and functioning each shift. The Administrator said the Maintenance Director checked each door every week to make sure that the wander guard system was working as well. The Administrator said the staff were provided with training on elopements because the facility had other residents elope back in November 2024. The Administrator said if a resident was able to elope from the facility they were at risk because it was not safe outside the facility. The Administrator said she expected staff to report when a resident eloped from the facility. Interview and observation on 05/15/25 at 12:53 PM with the Maintenance Director revealed he was notified of Resident #154's elopement back in April 2024 but he could not recall any of the details. The Maintenance Director said if Resident #154 eloped from the back door of the facility near the dumpsters it would have been the door near the therapy gym at the end of the 400-hallway. Observation of the door at the end of the 400-hallway revealed it had a wander guard system alarm on it and the door was locked and required a code to turn the alarm off. Observation of the door being pushed open revealed an alarm went off and staff would have to enter the code in to the keypad to turn the alarm off. The door led out to a small parking lot that had the facility's dumpsters off to the left side and a gas station could be seen across the street. In front of the gas station was a busy highway as well. The Maintenance Director said he checks to make sure the wander guard system was working on each of the exterior doors once a week and documents that on his check off sheet. The facility implemented the following interventions: Review of an in-service roster, dated 11/01/24, and titled Staff in-services initiated the following: .elopement policy . reflected 108 staff's signatures. Review of the facility's policy, dated January 2024, and titled Elopement Response Protocol reflected: 1. Conduct a thorough search of the Facility and its grounds .8. A complete head to toe nursing assessment must be completed upon return of the Patient [sic]. The Administrator was informed of the PNC IJ on 05/15/25 at 12:42 PM.

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	05/15/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who are fed by enteral means, received the appropriate treatment and services to prevent complications of enteral feeding, for 1 of 1 resident (Resident #45) reviewed for enteral nutrition. The facility failed to follow physician orders for Resident #45's enteral feeding tube to be flushed with 50 ml of water every 1 hour and feeding with Jevity 1.2 at 55mls/hr. This failure could place residents who had gastrostomy tube at risk for fluid deficit and over feeding. Findings included: Record review of Resident #45's quarterly MDS assessment dated [DATE], reflected the resident was a [AGE] year-old female who was admitted to the facility initially on 09/24/2024 and readmitted on [DATE]. She had diagnoses that included dysphasia (swallowing difficulties). Resident #45's BIMS score was 11 revealing moderate cognition. The MDS further revealed Section K (Nutritional approaches) indicated the resident's nutritional approach was a feeding tube. Record review of Resident #45's care plan dated 03/18/25 reflected: Focus: Resident #45 requires tube feeding rule out Dysphagia. Goal: will maintain adequate nutritional and hydration status aeb weight stable, no s/sx of malnutrition or dehydration through review date. Interventions: Administer enteral feeding/water flushes as ordered by physician. Record review of Resident #45's physician orders, dated 05/05/25, reflected an order for Enteral Feed Order flush feeding tube with 50 cc of water every 1 hour and another Enteral Feed jevity 1.2 at 55ml/hr. via feeding to run continuously. Observation and interview on 05/13/2025 at 10:55 AM, revealed Resident #45 lying in bed. Resident #45 was connected to her feeding pump, the Jevity1.2 formula bag was dated 05/13/25 at a rate of 65 mL/hr and the water bag was dated 05/13/25 with a rate of 35ml/hr . Observation and interview on 05/14/25 at 10:43 AM with LVN A, who was the charge nurse for Resident #45, revealed Resident #45 was connected to her feeding pump.The Jevity 1.2 feeding rate was set at 65 mL /hr, and the water flush rate was set at 35 mL every 1 hour. She stated she was aware the physician order for the flush was supposed to be 35 mL/hr and jevity 1.2 at 65mls/hr. She stated when she came in the morning, she only checked to ensure the feeding was flowing. She stated she did not check the settings. She stated she knew she was supposed to check the settings, but she forgot. LVN A stated Resident #45 had a g-tube, and the night shift had hung a new formula and water bag. She stated she was not aware that the orders had been changed. She stated failure to follow the physician orders could lead to dehydration and overfeeding that could lead to vomiting and aspiration. LVN A stated she had done training on gastronomy tubes regarding medication and feeding administration. (continued on next page)

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	05/15/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/14/25 at 02:30 PM with RN B, who was the charge nurse for Resident #45 on the second shift , revealed she was the one that had connected Resident #45 to her feeding pump on 05/13/25. She stated the feeding rate was set at 65 mL/hr, and the water flush rate was set at 35 mL every 1 hour. She stated she knew she was supposed to check the physician orders before hanging a new bottle of feeding and flushing water, but she did not check. She stated she was not aware that the orders had been changed. She stated failure to follow the physician orders could lead to dehydration and overweight. RN B stated she had done training on gastronomy tubes regarding medication and feeding administration. Interview on 05/14/25 at 02:51 PM with ADON N, revealed he was responsible of putting new orders given by dietician on the electronic records. He stated his expectation was for nurses to check orders before they hang the feeding bottle and the water flushes. He stated it was his responsibility to monitor nurses and ensure the pumps were set with the correct orders. He stated he had not been to Resident #45's room since the orders were changed. He stated the potential risk would be dehydration and weight gain. He stated he could not recall any in-service on g tube feeding administration. Interview with on 05/15/25 at 01:22pm with Regional Dietician she stated her expectation was nurses to carry out orders as given and follow instructions . She stated she changed the orders on 05/05/25 and she notified the ADON. She stated the risk of not following the orders would be dehydration and weight gain. Interview on 05/15/25 at 03:29 PM, the DON revealed she expected the nurses to follow physician and dietitian orders. The DON stated she also expected the nurses to set feeding pumps per the orders and check orders regularly for changes. The DON said the person responsible to ensure orders were followed, were nursing staff and ADON N. The DON said that ADON N was responsible to ensure orders were followed by nursing staff through audits and ensure the orders matches with the feeding and the flushes on the pump . She stated failure to follow the physician orders could lead to dehydration and weight gain. She stated she had done training with staff in April on g tube feeding and medication administration. Record review of the facility's training records for medication administration including tube feeding, dated April 13 2024, reflected RN B was not in attendance, but LVN A was in attendance. Record review of the facility's Enteral feeding safety precautions policy, dated MAY 2014 , reflected: .1.Check the enteral nutrition label against the order before administration. Check the following information . g. Rate of administration (ml/hour) .

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	05/15/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 2 residents (Resident #98) reviewed for dialysis. The facility failed to ensure dialysis communication forms for Resident #98 were completed with the resident's dialysis treatment information on the following dates: 05/02/25, 05/05/25, and 05/09/25. This failure could place residents at risk of inadequate communication between the facility and dialysis center. Findings included: Record review of Resident #98's admission record, dated 05/14/25, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Record review of Resident #98's admission MDS Assessment, dated 04/28/25, reflected she had a BIMS score of 10, indicating moderate cognitive impairment. Her active diagnoses included renal insufficiency, renal failure, or end-stage renal disease, heart failure, and respiratory failure. Her MDS indicated she received dialysis services. Record review of Resident #98's physician's orders, dated 05/14/25, reflected the following: - Dialysis- Post Tx Frequency in the evening every Mon, Wed, Fri Upon [sic] return, enter Dialysis Treatment Information received from Dialysis Center onto the Dialysis Communication Record. Complete the Post Dialysis Assessment Section. Check for any labs/ notes/ orders [sic] from the Dialysis Center with an active date of 04/29/25. - Dialysis- Pre Tx Frequency every day shift every Mon, Wed, Fri Complete Pre-Treatment section of Dialysis Communication Record. Print record and place in Dialysis Communication Folder prior to Transport. Ensure Food and/ or [sic] Meal goes with patient to each Dialysis treatment. with an active date of 04/29/25. Record review of Resident #98's care plan, initiated 04/23/25, reflected the following: Focus: The resident needs dialysis . Record review of Resident #98's Dialysis Communication Forms, dated 05/02/25 and 05/05/25, reflected only the Pre-Dialysis Information was filled in; the Dialysis Information was left blank. Record review of Resident #98's Dialysis Communication Form, dated 05/09/25, reflected the Pre-Dialysis Information was filled in, but the Dialysis Information had N/A written in each spot. (continued on next page)

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	05/15/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 05/13/25 at 11:26 AM with Resident #98 revealed she was lying in bed and was sleepy. Resident #98 said she never has any issues when she went to dialysis. Interview on 05/14/25 at 12:58 PM with LVN D revealed Resident #98 went to dialysis on Mondays, Wednesdays, and Fridays. LVN D said she worked the 6 AM to 2 PM shift so she sent Resident #98 to dialysis with a red binder. LVN D said the binder included her face sheet, orders, and dialysis communication form filled out for the pre-dialysis information. LVN D said Resident #98 did not come back on her shift from dialysis, so the 2 PM to 10 PM shift nurse on duty would be responsible for completing Resident #98's dialysis forms. Interview on 05/15/25 at 2:48 PM with LVN E revealed Resident #98 went to dialysis in the mornings on Mondays, Wednesdays, and Fridays and came back during her shift around 5:30 PM/6 PM. LVN E said Resident #98 left to go to dialysis with a red binder that included her dialysis communication forms. LVN E said the morning nurse for Resident #98 filled out the pre dialysis information on the form and the dialysis center was supposed to fill out the rest of the form and return it with the resident. LVN E said the dialysis center has not been returning the forms filled out for Resident #98 and when that happened she would call the dialysis center to get the information. LVN E said sometimes she was able to get in touch with someone at the dialysis center for the information and sometimes it was more difficult. LVN E said she was responsible for making sure the post dialysis information was included on the forms and filled out since she was the nurse on duty at the time the resident was brought back to the facility from dialysis. Interview on 05/15/25 at 3:01 PM with the DON revealed since Resident #98 came back to the facility from the dialysis center, the afternoon shift nurse would have been responsible for completing the dialysis communication form was filled out. The DON said the purpose of the form was to make sure the resident's vitals were okay and to communicate anything that required any follow-up. The DON said the ADON was responsible for making sure that the nurses were completing the dialysis communication forms for residents. The DON said she expected all staff to complete the dialysis communication form for residents and they had been trained to do that. The DON said if the dialysis communication form was not completed, the facility may not know how stable a resident was so they might send them to the hospital for something that the facility could have handled in house. Interview on 05/15/25 at 3:30 PM with ADON F revealed she was the ADON in charge of Resident #98's hall. ADON F said she checked the dialysis communication forms for completion about once a week. ADON F said she was not aware that Resident #98's dialysis communication forms were not completed. Record review of the facility's policy, dated August 2007, and untitled reflected the following: .7. The [Management Company's Name] will send a Dialysis Communication Record .to the dialysis center upon each dialysis visit. The [Management Company's Name] will complete the top section of the form, entitled 'Nursing Home Nurses' and provide to the Resident [sic] prior to exiting the center .8. The dialysis center should be encouraged to complete the middle section of the Dialysis Communication Record and return to the [Management Company's Name] .9. The [Management Company's Name] nurse will complete the Post Dialysis Assessment section of the Dialysis Communication Record and file the form in the dialysis binder.

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	05/15/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident on one of three medication carts (500 hall) and 2 of 2(Residents #25 and #59) reviewed for pharmacy services. The facility failed to ensure the 500 Hall nurses' medication cart contained accurate narcotic logs for Resident #25 and #59 on 05/14/25. These failures could place residents at risk for medication error, and drug diversion. Findings included: 1. Review of Resident# 25's Quarterly MDS Assessment, dated 12/29/24, reflected the resident was [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included Hip and Knee Replacement. The resident had moderately impaired cognition with a BIMS score of 10. Review of Resident #25's physician's orders dated 2/27/25 reflected an order for the resident to receive one tablet of Acetaminophen-Codeine Tablet 300-30MG (pain medication) by mouth as needed every six hours. 2. Review of Resident# 59's Quarterly MDS assessment, dated 04/07/25, reflected the resident was [AGE] year-old male admitted to the facility on [DATE], with diagnoses that included pain. The resident had intact cognitive with a BIMS score of 15. Review of Resident #59's physician orders dated 04/13/24 reflected an order for the resident to received 1tablets of hydroco/apap tab 10-325mg by mouth every 6 hours for pain. Observation and record review on 05/14/25 at 8:52 AM of 500 Hall nurses' medication cart and the Narcotic Administration Record, with LVN C, revealed the following: Resident #25's Narcotic Administration Record for Acetaminophen-Codeine Tablet 300-30MG reflected a total of 51 pills remaining, while the blister pack count was 50 pills. It was last administered on 05/14/25 at 7:00AM. Resident #59's Narcotic Administration Record sheet for hydrocodone-acetaminophen 10-325 mg was last signed off on 05/14/25 for one-tablet dose given at 7:00 AM, for a total of 82 pills remaining, while the blister pack count was 83 pills. (continued on next page)

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	05/15/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN C on 05/14/25 at 10:58 AM revealed she did not realize the narcotic count and narcotic log was not matching and she did not know she was missing 1 tablet.She checked on her MAR and she found out she had administered on 5/12/25 and she forgot to log of, and nobody had noted during shift change.LVN C stated she had administered medication to Resident#25 on 5/15/24 at 7:00AM and she did not compare the count and what was remaining,and she knew she was supposed to reconcile after administering . She stated failure to log after medication administration would cause drug diversion. She stated the Narcotic log should always match with the count.LVN C stated for Resident #59 hydrocodone-acetaminophen 10-325 mg by mouth every 6 hours for pain she stated she had signed off on 5/14/25 at 7:00AM and she got destructed and she forgot to administer to resident. She stated she knew she was supposed to sign-out on the narcotic count sheet after administration and on the Medication Administration Record, but she did not. She stated signing off when no medication was administered it could lead to medication error. She stated she had done an in-service on medication administration, but she could not recall when. Interview on 05/15/25 at 10.35AM with Resident #59 revealed he get his pain pill every morning with other medications. He stated on 5/14/25 for some reasons LVN C came back at around 10:00AM and told him she had forgotten to administer the pain pill. He stated he does not ask for the pain pill but when nurses are administering the morning medications would ask whether he need pain pill and they would administer. Interview on 05/15/25 at 10.35AM with Resident #25 revealed she get pain pill every morning before therapy and again at night before she sleeps. Interview on 05/15/25 at 03:21 PM, the DON revealed her expectation was for staff administering narcotic medications to document the medications when they were given to the resident on the medication administration record and to sign on the narcotic log to prevent discrepancies and to have proof the medications were administered. She stated the oncoming should count with outgoing staffs each shift and report any discrepancies. She stated the Narcotic administration record should match the count . She stated when she was notified she went back to the medication administration record, and she found out that LVN C had administered medication on 5/12/25 which was not logged off on the narcotic administration record . The DON stated nobody follows behind the nurses ,the nurses are supposed to check on each other ensuring the counts are correct. She stated Failure to document could lead to discrepancy and adverse effects like pain not being controlled .She stated her expectation was nurses to be completing one task before going to another task . She stated she had done training on medication administration. Review of the facility trainings reflected all as needed controlled substance must be documented on medication administration this is the only record of administration.The controlled substance reconciliation log if not a record of administration. Narcotics needs to be signed as you give them on 04/13/25 and LVN C was in attendance . Review of the facility's current Management of Controlled Medication - policy, dated January 2024, reflected: g. You must administer medication and sign the medication administration record and sign the medication administration record according to facility policy(either pop-sign-give)or (pop-give-sign),please ask and know your facility policy on this procedure prior to passing medications .

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	05/15/2025

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 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 the medication error rate was not five percent (5%) or greater for one of three staff (LVN Q) which resulted in a 10% medication error rate after 30 opportunities with 3 errors for one of five residents (Residents #97) reviewed for medications. LVN Q crushed all medications and mixed them all together into one cup of pudding without an order to do so for Resident #97, creating an error rate of 10%, (3 errors out of 30 opportunities). This failure could place residents at risk of physical and chemical incompatibilities leading to an altered therapeutic response. Findings included: Record review of Resident #97's comprehensive MDS assessment, dated 04/21/25, revealed a [AGE] year-old male who was admitted to the facility on [DATE].The assessment reflected the resident cognition was severely impaired with a BIMS score of 5.The resident had diagnoses which included pneumonia(infection that inflames the air sacs in one or both lungs) and chronic kidney disease(a condition where the kidneys are damaged and cannot filter blood as effectively as they should). Record review of Resident #97's, May 2025, Physician Orders revealed the following order: -Bismuth/Metronidazole/Tetracycline Capsule 140-125-125 MG(Bismuth Sub citrate Potassium-Metronidazole-Tetracycline).Give 3 capsules by mouth three times a day. -Ascorbic Acid Tablet 500 MG. Give 1 tablet daily -Renal-Vite Oral Tablet 0.8 MG(B-Complex w/ C & Folic Acid).Give 1 tablet daily. Observation on 05/14/25 8:40 AM, revealed LVN Q crushed the following 2 medications for Resident #97 and opened three capsules put them together in one medication cup and mixed with pudding: -Bismuth /metronidazole/tetracycline capsule 140-125-125,3 capsule three times, -Renal vite 0.8 mgs b- complex v and folic acid 1 tablet daily -Vit C 500mgs 1 tablet daily She then administered all three medications embedded in pudding in one cup by mouth to Resident #97. Interview with LVN Q on 05/14/25 8:43 AM revealed she did not have a physician's order to crush and mix medications for Resident #97. She stated she was not aware she was supposed to have an order to crush and mix and she stated she need to inquire from her ADON. She stated she had been crushing and mixing since the resident had been there in the facility. She went to ask and came back and stated she was supposed to have an order to crush and mix together the medication. She stated the risk of mixing was drug interaction she stated she had done training on medication administration. (continued on next page)

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	05/15/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with ADON N on 05/14/25 12:59 PM revealed the facility staffs are supposed to have an order to crush and mix. ADON N stated the facility had a standing order for crushing medication but was not included on Resident #97 physician orders. to crush unless contraindicated. The DON stated he was not sure whether they should have orders to mix after crushing all the medications together. ADON N stated LVN Q was supposed to check orders before mixing into the cup and after crushing. He stated the risk of crushing and mixing was drug interaction. He stated facility had done in-service on medication administration. Interview with DON on 05/15/25 3:35 PM revealed her expectation was nurses should have physician orders to crush and mix medication. The DON stated the facility had standing orders to crush ,but she realized they were not on Resident #97 medication administration record. She stated her expectation was nurses should put all medications in different cups because of contraindications and interactions and incase the resident denies taking one it would be easier to separate. The DON stated she had completed training on medication administration with staff. Record review of the facility's current Administering Medication training dated 4/13/25 reflected the following: i. Do not crush meds without appropriate may crush meds order on medication administration record, this requires a physician order after speech therapy evaluation and a care plan for administration of crushed medication.

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	05/15/2025

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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promptly notify the physician of laboratory results in accordance with facility policy and procedures for notification for 1 of 5 residents (Resident #306) reviewed for laboratory services. The facility failed to send Resident #306's weekly labs to the infectious disease doctor while the resident resided at the facility from 11/27/24 to 12/20/24. This deficient practice placed the residents at high risk of not receiving treatment, and/or developing complications. Findings included: Review of Resident 306's MDS dated [DATE] reflected the resident was [AGE] year-old female admitted to the facility on [DATE] and discharged on 12/20/24. Her diagnoses included diabetes and anxiety disorder. Resident #306 had a BIMS of 6 indicating her cognition was severely impaired. The MDS also reflected the resident had a stage 4 pressure ulcer. Review of Resident #306's care plan effective on 11/28/24 reflected the resident had pressure ulcers to her right heel, unstageable to right hip, and stage 4 to the left lateral ankle. Interventions included to obtain labs per physician orders. Review of Resident #306's discharge hospital records dated 11/27/24 reflected the following: Labs to be followed: weekly CRP (a blood test that measures the level of CRP, a protein produced by the liver in response to inflammation)/BMP (measures eight different substances in your blood and it provides important information about your body's fluid balance, your metabolism and how well your kidneys are working)/CBC (group of blood tests that measure the number and size of the different cells in your blood) faxed to the office of [Doctor] Review of Resident #306's facility clinical record revealed labs were obtained on 12/02/24, 12/09/24, and on 12/16/24. Interview on 05/15/25 at 12:13 PM with Resident #306's family revealed the resident was discharged from the facility on 12/20/24. The family said the infectious disease doctor had ordered for the resident to have weekly labs drawn and faxed over to his office and the doctor's clinic said they had never received any of the lab requested. Interview on 05/15/25 at 11:47 AM with the Infectious Disease Doctor's clinic revealed they had called the facility on 12/02/24, 12/18/25 and on 12/31/24 to try and obtain Resident #306's labs copies. The clinic said that on 12/31/24 the facility finally sent one set of labs that were dated for 12/02/24. The Infectious Disease Clinic further stated the doctor would have wanted to keep up with the resident's infection treatment. (continued on next page)

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	05/15/2025

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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/15/25 at 2:42 with ADON N revealed he will send or fax labs when he was asked but he could not specifically recall if he had sent Resident #306's labs to the infectious disease clinic. Interview on 05/15/25 at 2:55 PM with the DON revealed she thought she was sure she had asked ADON N to fax Resident #306's labs results to the infectious disease clinic. The DON further stated she did not know what else could have happened with the labs during that time. Review of the facility's policy titled Lab and Diagnostic Test Results - Clinical Protocol revised on 09/2012 reflected the following: Assessment and Recognition 1. The physician will identify and order diagnostic lab testing on diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility 1. A physician can be notified by phone, fax, voicemail, e-mail, mail, pager, or a telephone message to another person acting as the physician's agent a. Facility staff should document information about when, how, and to whom the information was provided and the response

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	05/15/2025

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure each resident received, and the facility provided food prepared in a form designed to meet individual needs for 1 of 8 residents (Resident #80) reviewed for regular ground diet needs. The facility failed to provide Resident #80 with his regular ground foods (mechanically altered diet that was prescribed for individuals who have difficulty chewing or swallowing food) as designated on his meal ticket on 05/14/25. This deficient practice could place residents at risk for poor food intake, weight loss, and not having their nutritional needs met. The findings included: Record review of Resident #80's face sheet dated 05/15/25 reflected the resident was a [AGE] year-old male who admitted to the facility on [DATE]. Record review of Resident #80's quarterly MDS Assessment, dated 04/15/25, reflected the resident had an active diagnosis of protein-calorie malnutrition, essential hypertension, depression and bipolar disorder. Resident #80's BIMS score of 03 indicating severe cognitive impairment. Record review of Resident #80's Care plan reflected Weight gain aeb 25lbs/90days. (13.2%) Regular Ground diet. 5/12/25: Weight Gain of 19.80lbs/180days (10.1%). Goal: The resident will not develop complications from weight gain such as skin breakdown, ineffective breathing pattern, altered cardiac output, diabetes, impaired mobility through review date. Intervention: Resident encouraged to eat meals in the DR if tolerated. Interview on 05/13/25 at 03:24 PM, Resident #80 stated he was doing well. Resident #80 stated the only concern he had was that his meals had been a liquid/pureed texture instead of his food being cut/chopped. Resident #80 stated he did not like being served pureed foods. He stated when he gets the liquid texture he does not want to eat it. Observation on 05/14/25 at 12:20 PM, Resident #80 was provided with pureed consistency meal. Lunch meal consisted of pureed texture Salisbury steak, mashed potatoes and carrots. Resident #80's meal ticket indicated Regular Ground. Observed Central Supply feeding Resident #80's pureed lunch. Observation and interview on 05/14/25 at 12:28 PM, RD reviewed Resident #80's meal ticket, observed resident lunch and revealed Resident #80's was provided with the wrong food texture. RD stated resident should be on regular ground and not pureed. Resident #80 was provided with the correct meal texture. Interview on 05/14/25 at 12:38 PM with Director of Rehab revealed Resident #80 was on regular ground texture. (continued on next page)

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	05/15/2025

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 05/14/25 at 12:42 PM with Central Supply staff revealed each resident should receive what was on the meal ticket. She stated she glanced at the meal ticket to verify the name but did not ensure the food texture was correct. She stated since the nurse had checked it prior to giving her the lunch tray, she assumed the food was correct. Interview on 05/14/25 at 12:47 PM, Resident #80 stated it had been a while since he was provided with the correct food consistency. Resident #80 stated he had been provided with pureed food and he did not like that. Interview on 05/14/25 at 1:40 PM, Dietary Manager revealed his expectations were for all staff to follow meal tickets. He stated platting starts with the [NAME] and ends with the nurse verifying the residents receiving the correct meal. Dietary Manager stated today (05/14/25) the DON was checking meal tickets, and it was her responsibility to verify residents received the correct meal tray. He stated Resident #80's lunch meal should had been corrected before it was serviced to him. Dietary Manager stated there was no potential risk to the resident; however, it was a downgrade of texture. Interview on 05/14/25 at 1:48 PM, RD revealed her expectations were for all staff to follow exactly what was on the meal ticket. She stated they have a nurse who double checks the meal trays to ensure the trays are correct. RD stated today (05/14/25) the DON was checking the meal trays and meal tickets. She stated there was an error on Resident #80 lunch meal, he received pureed texture instead of regular ground. RD stated there was no potential risk of chocking since it was pureed; however, it was a downgrade of texture. Interview on 05/15/25 at 2:57 PM, the DON stated she was responsible for verifying meal tickets. She stated she observed Resident #80's tray and she observed ground meat. She stated when reviewed the meal tickets she ensures the food being plated matches the meal ticket. Record review of facility Therapeutic Diets policy, revised 10/2017, reflected the following: 1. Diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes. Diagnosis alone will be determined whether the resident is prescribed a therapeutic diet.