STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675811	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Gardens of Frisco	10700 Rolater Dr Frisco, TX 75035

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675811	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Gardens of Frisco	10700 Rolater Dr Frisco, TX 75035

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Findings included: 1. Record review of Resident #1's Face Sheet, dated 10/23/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with obesity (excessive accumulation of body fats) and dementia (a condition characterized by loss of memory and ability to reason). Record review of Resident #1's Comprehensive MDS (assessment used to determine functional capabilities and health needs) Assessment, dated 10/02/2025, reflected the resident had as severe impairment (resident required significant assistance and support in daily life) in cognition with a BIMS (screening tool used to assess cognitive status) score of 03. The Comprehensive MDS Assessment indicated the resident had dementia and obesity. Record review of Resident #1's Comprehensive Care Plan, dated 10/12/2025, reflected the resident had the potential for impaired skin integrity and one of the interventions was to provide proper skin care. Record review of Resident #1's Physician Order, dated 10/08/2025, reflected Apply Antifungal powder to groin area after each perineal (area between the thighs) care. every shift for Skin redness AND as needed. Record review of Resident #1's Assessment Notes on 10/23/2025 reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment the resident was competent to manage their own medications. During an observation and interview on 10/23/2025 at 8:43 AM revealed Resident #1 was in her bed eating breakfast using her overbed table. It was observed that an anti-fungal powder was also on top of the overbed table and was in plain view. The resident gestured that it was used on her groin. The resident shook his head when asked if he was applying the anti-fungal. 2. Record review of Resident #2's Face Sheet, dated 10/23/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with depression. Record review of Resident #2's Comprehensive MDS Assessment, dated 09/24/2025, reflected the resident was cognitively intact (resident capable of normal cognition and needs little support) with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had depression. Record review of Resident #2's Comprehensive Care Plan, dated 10/17/2025, reflected the resident had depression and the interventions were to administer antidepressant and monitor effectiveness. Record review of Resident #2' Physician Order on 10/23/2025 reflected the resident did not have orders for Systane eyedrops. Record review of Resident #2's Assessment Notes on 10/23/2025 reflected no assessment for self-administration of medications, no clear instructions for self-administration, and no assessment the resident was competent to manage their own medications. During an observation and interview on 10/23/2025 at 9:06 AM revealed Resident #2 was in her bed, awake. It was observed that three bottles of Systane eyedrops were on top of the resident's overbed table and were in plain view. The resident said the eyedrops had always been on top of her table. She said she was not using them. 3. Record review of Resident #3's Face Sheet, dated 10/23/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. The resident was diagnosed with depression. Record review of Resident #3's Comprehensive MDS Assessment, dated 08/27/2025, reflected the resident had severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated the resident had depression. Record review of Resident #3's Comprehensive Care Plan, dated 10/12/2025, reflected the resident had depression and one of the interventions was to administer medications as ordered. Record review of Resident #3' Physician Order on 10/23/2025 reflected no order for nasal spray. Record review of Resident #3's Assessment Notes on 10/23/2025 reflected no assessment for self-administration of medications, no clear instructions for self-administration, and no assessment the resident was competent to manage their own medications. During an observation and interview on 10/23/2025 at 9:13 AM revealed Resident #3 was in her bed, awake. It was observed that a nasal spray was on top of the resident's dresser. The dresser was located few steps away from the door and the nasal spray was on plain view. When asked about the nasal spray, the resident did not reply. In an interview on 10/23/2025 at 10:07 AM, LVN C stated there should be no medications inside the rooms of the residents unless they had an assessment that they could self-administer their medications. He said it might result in overmedication and adverse reactions. He said the residents might be taking them every hour and nobody would know. He said confused residents might enter the room, get ahold of the medications, and consume them. He saw Resident #1's anti-fungal and said he had not applied yet the resident's anti-fungal so he did not know who left the anti-fungal on top of the Resident #1's overbed table. He said the resident might be confused or have poor eyesight and put the anti-fungal powder on her food. He saw Resident #2' eye drops