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	01/14/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for one (Resident #1) of four residents reviewed for call lights.The facility failed to ensure Resident #1's call light was within reach of the resident. This failure could place the residents at risk of falling, injury, and feelings of low self-worth due to not being able to call for help. Findings included:Review of Resident #1's face sheet, dated 01/14/26, reflected the resident was a [AGE] year-old female, admitted on [DATE]. Her diagnoses included muscle wasting and atrophy (loss of muscle mass and strength), bi-polar disorder, depression, history of stroke (a blood clot in the brain, which damages the brain), seizures, reduced mobility, and anxiety disorder. She also had diagnoses of cognitive, speech and language deficits, and hemiplegia and hemiparesis (weakness and paralysis) of her left side as a result of stroke. Review of Resident #1's annual MDS assessment, dated 11/05/25, reflected she had serious mental illness. She was able to be understood by others, and usually was able to understand others. Her BIMS score was 14, indicating a likelihood of intact long and short-term memory. Resident #1 exhibited fluctuating inattention, disorganized thinking, and altered level of consciousness. Her mood interview score was one, indicating a low likelihood of her being depressed in the two weeks before the assessment, though she did answer that she often felt lonely or isolated from those around her. Resident #1 exhibited verbal and other (not directed toward others) behavioral symptoms daily during the seven-day assessment period. Her behavioral symptoms significantly interfered with her participation in activities or social interactions, and significantly disrupted the living environment for others. Functionally, Resident #1 was able to feed herself, only requiring staff to set up her meals and clean up afterward. She was fully dependent on staff for rolling onto her side, bathing, toileting hygiene, and dressing her lower body, and was only able to do less than half the effort in upper body dressing and personal hygiene. During the assessment period, Resident #1 had not been able to sit, stand, walk, or be transferred, except for a shower. She was always incontinent of bowel and bladder. Resident #1 had almost constant pain, and received scheduled and as-needed medications for pain. She answered that her pain was at a level of nine out of ten. Review of Resident #1's care plans reflected the following:- Behavior of calling 911 for non-emergency situations, dated 02/19/25 and revised 11/12/25- Behavior of calling facility phone stating severe pain and also calling family member stating she was being refused treatment when it was not yet time for pain medication (pain management has made several adjustments), and rating her pain a 10 while falling in and out of sleep, dated 05/15/2025, and revised 11/12/25-Behavior of yelling out instead of putting call light on. When staff answers her she will state that she doesn't know whyshe is yelling, dated 05/15/2025, and revised 11/12/25- Behavior of being verbally aggressive related to ineffective coping skills, mental/ emotional illness, and poor (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impulse control, dated 05/15/2025, and revised 11/12/25 An interview and observation on 01/14/26 at 2:10 PM revealed Resident #1 in bed, lying on her back awake. Resident #1 complained that it was hard to get staff to come take care of her, and she felt they were dismissive of her because she yelled, but she yelled, because she needed help. When asked why she did not use her call button, which was hanging off the left side of her bed with the bed remote control at the time of this interview, she said she never could find it. She said it always fell, and she could not use her left side at all. She felt for the call button on her right side, and attempted to reach it when the surveyor told her it was hanging off that side of the bed, and was unable to reach the cord to pull the call button within her reach. She said that she yelled for help, and sometimes called her family members to call the facility and tell the staff she needed help. She said it made her feel bad, and like the people there did not care about her. She said she did not remember the call button ever having a clip on it (for clipping it to her gown or bedding), and she did not think she ever had used a touchpad type of call button. An interview and observation on 01/14/26 at 2:20 PM with MA A revealed that when she left a room after providing medications, she would check to make sure the call light button and bed remote were within reach of a resident. She said the resident had a clip on the call button before, but she moved around and knocked it off the bed. She placed the remote and the call button on the resident's upper abdomen and said that was where they normally put it, so she could reach it. When the surveyor pointed out that the resident's body was not a flat surface and it appeared that it slid off, she agreed, and said that they needed to find another solution. An interview on 01/14/26 at 4:13 PM with the ADON revealed Resident #1 could be confused at times and say one thing, and say a different thing the next time she spoke about something. She said it was still all staff's responsibility to make sure the call lights were within reach of the residents. She said the type of button a resident had was dependent on their needs, and that Resident #1 had a clip on hers before, but it must have come off. She said the staff was able to alert the maintenance person to place a clip on the button, if someone needed one. She said Resident #1's call button did drop sometimes, but the resident had never complained to her about not being able to reach it. She said it was important because a resident might need to call for help, and it could be the only way they could communicate that to the staff. An interview on 01/14/26 at 4:35 PM with the Administrator revealed his expectation was that call lights were in reach of residents, so they could call for assistance, and answered in a timely manner. He said if the resident kept knocking the button off their bed, the staff should keep replacing it every time. An interview with CNA B on 01/14/26 at 4:54 PM revealed she was the CNA on Resident #1's hall on the evening of this interview. She said it was important to keep the call lights where the residents could reach them, so they did not fall trying to get up to do things for themselves. She said that she was not aware of Resident #1 having an issue with her call button, and if the resident knocked the button off their bed often, the staff were to clip the button to the resident's gown, so it was easy for them to reach. She said if the button did not have a clip, she would just keep replacing it when it fell, or look for a clip to put on it. She said the clips were easy to find and she thought Resident #1 had one once, and she thought she had the pad type of button to push. She said Resident #1 did use her call light sometimes, and she often yelled to get help. An interview on 01/14/26 at 5:20 PM with the DON revealed the call button should always be in a position where the resident could reach it, and staff should always check to make sure it was in a position the resident could reach, and that it was a type the resident was able to use. She said if they knocked it off the bed, it should have a clip on it, and sometimes she tied them to the bed, where the resident could reach it if it fell, to pull it back to them. She said the staff also should re-educate (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and remind residents about the use of the call light. She said it was important to have the button close because it may be the resident's only way to get help, but that she did tell her patients that if they dropped the light and they could speak, to yell and the staff would come fix it. An interview on 01/14/26 at 5:41 PM with the Administrator revealed that he could run out of fingers and toes trying to count the number of times he personally had gone into Resident #1's room because she was yelling, and when he would ask her why she did not use her call button, she would say she did not have one, and he would tell her it was right on her chest. He said the way she would lie in bed she could not see her chest, but would be able to reach her chest to find it. Review of the policy Resident Call Light System, revised in June 2023, reflected: Purpose: The purpose of this procedure is to respond to the resident's requests and needs. Policy Implementation: A call light system (audible and visual) is in place and operative in the facility. This system allows individual residents to access a system that notifies nursing that the resident has a need. Residents can communicate with the Nurse's Station from their room and/or bathing and toileting facilities. General Guidelines: 1. Explaining the use of the call light to new residents or as necessary. 2. Demonstrating the use of the call light. 3. Return demonstration may be utilized to ensure the resident can operate the system. 4. Ensure that the call light is easily reachable by the resident. (.)