

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675811	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Victoria Gardens of Frisco		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. The facility failed to ensure the dry storage food items were dated, labeled and securely stored. The facility failed to ensure the refrigerator food items were dated, labeled and securely stored. The facility failed to ensure the freezer food items were dated, labeled and securely stored. The facility failed to ensure that canned good food items were free of dents. The facility failed to ensure that the kitchen equipment (steam tray table, floors, ovens, drain) was clean. The facility failed to ensure that dishwashing protocol was followed for the 3-compartment sink. The facility failed to ensure baked bread rolls were covered prior to serving. The facility failed to ensure milk temperatures were taken and logged. The facility failed to ensure milk was kept cold. The facility failed to ensure a bread roll was not taken off a prepared plate and put back onto the bread roll pan. The facility failed to ensure plastic oven bags were not burnt to metal pans containing cooked rice. These failures could place residents at risk for foodborne illness and foodborne intoxication. Findings included: During an observation on 07/07/2026 at 8:31 AM of the facility's only kitchen revealed: Observation on 07/07/2026 at 8:33 AM of the dry storage closet: An unsealed bag of cocoa powder, dated 5-16-23 large containers, one with a dry mix, 2 with dry pasta noodles, undated and unlabeled a box with an opened and unsealed bag of parboiled rice, undated a bag of saran wrapped tortilla chips, undated and unlabeled a bag of cereal, not thoroughly sealed and undated a bag of brown gravy dated 06/15/26, with no indication if the date was delivered on, opened on, or to be used by a bag of strawberry gelatin, dated 07/04/2026, with no indication if the date was delivered on, opened on, or to be used by the following dented cans: Crushed Pineapple, dated 6-5 4 cans of Diced Peaches, dated 06-29-26 Kidney Beans, dated 7-2-26 salsa de chile (chili sauce), dated 4/30 large container of Fish fry mix dated 3-16 and 4, 6, 9-16 and the corner of the tub was broken off, exposing the mix Observation on 07/07/2026 at 8:41 AM of the 3-compartment sink revealed used dishes soaking in the 1st compartment (wash compartment); no water in the 2nd compartment (rinsing compartment); dishes sitting in the 3rd compartment (sanitizing compartment), with no sanitizer solution. Directions on how to use the 3-compartment sink were posted above the sink and on the outer side of each compartment. The directions stated to wash dishes in the 1st compartment, using clean water and detergent solution; rinse dishes in the 2nd compartment using clean water; sanitize the dishes in the 3rd compartment using clean water and sanitizer solution. Observation on 07/07/2026 at 8:42 AM of the walk-in refrigerator: an open bag of mild cheddar cheese, undated one box of premade mini blueberry muffins, undated, unlabeled, and unsealed a bag of Parmesan cheese labeled and dated with prepared date 06/01 and sealed bag dated 07/02 a container of mixed fruit dated June 30 3:30 PM a metal tin of prepared white gravy, undated and unlabeled an opened package of turkey deli meat, (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	undated and unsealed a large mixing bowl covered with saran wrapped, with a brown meat-like substance mix in the bowl, undated and unlabeled Observation on 07/07/2026 at 8:46 AM of the walk-in freezer: an open box containing an unsealed bag of frozen chicken tenders dated 7/6/26 an open box containing an unsealed bag of frozen beef patties dated 7/6/26 During an interview on 07/07/2026 at 8:50 AM with the DM revealed the mini blueberry muffins and parboiled rice were opened Monday (07/06/2026), the bags of cheese were recently opened, and the unlabeled bag of tortilla chips had been in dry storage since she began working at the facility a month ago. The DM said dented canned foods were a risk to residents because they could get botulism (foodborne illness) if the food was consumed. The DM said it was important to date, label and make sure food items were sealed so nothing got into foods, food was kept fresh, and to make sure nothing expired was served to residents. She said food items needed to be dated with the date they were delivered to the facility on, the date they were opened on, and the date to use the food item by. During a follow-up observation on 07/08/2026 at 11:47 AM of the facility's only kitchen revealed: the open grates on the steam tray table had an accumulation of dark debris in the water that was used to keep prepared food items warm 2 pans of bread rolls were taken out of the oven, one pan was placed on the steam tray table, and one pan was placed on the gas stove top. Both pans were left uncovered Dietary Aide B washing dishes in the 3-compartment sink. Diet aide B washed a food preparation bowl in the 1st compartment, used running water to rinse the bowl, he then shook the water off the bowl and placed the bowl on a dish rack. Diet aide B did not use the 2nd and 3rd compartments of the sink. resident drinks, for lunch, were sat out on a cart and not kept cool for 90 minutes. Drinks included water, tea, fruit juice, and milk. the kitchen's gas stove top and oven had food particles, grease, and dust on the tops and side of them. The floors had oats from breakfast on them. The clean plate holder for the tray lane had food particles on it. a large metal pan of prepared rice was sitting on a cart, unsealed and uncovered. The pan was lined with a large plastic oven bag, and the food was inside the plastic bag. The edges of the metal pan revealed the plastic had melted to the pan and had begun to flake During an interview on 07/08/2026 at 12:11 PM with the DM, she stated she did not believe the plastic was in the rice since it had burned on the top outer edges of the metal pan. She scooped rice from the middle of the metal pan to serve to the residents. Observation and record review on 07/08/2026 at 12:18 PM of the facility's only kitchen revealed there was a Weekly Cleaning Schedule on the stand-by refrigerator that included different tasks assigned to different dietary members. The food temperature log was on a food preparation table; temperatures were not taken for the milk served at lunch. Observation on 07/08/2026 at 12:32 PM of the DM revealed she gotten more rice from the center of the pan to serve to residents and then covered the rice. During an interview on 07/08/2026 at 12:34 PM with the RD, he saw the plastic burnt on the edges of the pan with rice. He had the DM come and look at the pan and the DM said she did not see plastic in the rice. The RD said he had the DM dump the rice (due to risk of cross contamination), and replace the rice with noodles, an equivalent carbohydrate source. During an observation on 07/08/2026 at 12:51 PM of the staff plating resident's lunch, Dietary Aide C took a bread roll off of a resident's plate, and placed it back onto the pan of bread rolls. Record review, at that time, revealed the resident's meal ticket said he preferred no bread with their meals. An observation and interview on 07/08/2026 at 1:05 PM with [NAME] D revealed he was not utilizing the 3-compartment sink correctly when washing dishes. He washed dishes in the 1st compartment and used running water to rinse in the 2nd compartment and then sat them in the 3rd compartment. [NAME] D told the state surveyor how he usually used the 3-compartment sink properly, but there was only one drain stopper for the sink that worked well. He said it had been like that since he had started working at the facility a couple months ago. [NAME] D (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	next assignment. Record review of the facility's Food Receiving and Storage policy, dated 07/2014, reflected: Policy StatementFoods shall be received and stored in a manner that complies with safe food handling practices.Policy Interpretation and Implementation1. Food Services, or other designated staff, will maintain clean food storage areas at all times.6. Dry foods that are stored in bins will be removed from original packaging, labeled and dated (use by date). Such foods will be rotated using a first in - first out system.7. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).10. The freezer must keep frozen foods frozen solid. Wrappers of frozen foods must stay intact until thaw-ing.All foods belonging to residents must be labeled with the resident's name, the item and the use by date.Beverages must be dated when opened and discarded after twenty-four (24) hours.e. Other opened containers must be dated and sealed or covered during storage. Record review of the facility's Preventing Foodborne Illness - Food Handling policy, dated 07/2014, reflected: Policy StatementFood will be stored, prepared, handled and served so that the risk of foodborne illness is minimized.Policy Interpretation and ImplementationThis facility recognizes that the critical factors implicated in foodborne illness are:Poor personal hygiene of food service employees;Inadequate cooking and improper holding temperatures;Contaminated equipment; andWith these factors as the primary focus of preventative measures, this facility strives to minimize the risk of foodborne illness to our residents.All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents.Functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day and documented according to state-specific requirements. Federal standards require that refrigerated food be stored below 41 F, and that freezers keep frozen foods solid.Potentially hazardous foods will be cooked to the appropriate internal temperatures and held at those temperatures for the appropriate length of time to destroy pathogenic microorganisms.Potentially hazardous foods held in the danger zone (41 F to 135 F) for more than 4 hours (if being prepared from ingredients at room temperature) or 6 hours (if cooked and then cooled) will be discarded.Food that has been served to residents without temperature controls (e.g., trays, snacks, etc.) will be discarded if not eaten within two hours.All food service equipment and utensils will be sanitized according to current guidelines and manufacturers' recommendations.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation, interview, and record review, the facility failed to provide a private meeting space for residents' monthly council meeting for 1 of 1 confidential resident reviewed for resident council during survey. The facility failed to provide a private space for resident council meetings. This failure could place residents, who attended resident council meetings, at risk of not being able to voice concerns, grievances not being addressed, and fear of retaliation. Findings Included: An interview on 07/07/2026 at 9:59 AM with Activity Director revealed resident council meetings were being held in the main dining room. She stated they were conducting the meetings in the activity office, but the area was no longer large enough for all who wanted to attend. An observation on 07/08/2026 at 2:30 PM with Resident Council revealed meeting was held in main dining room. Room did not have doors to close and provide privacy. During meeting, staff members walked through dining room, kitchen staff could be heard, and residents could not confidentially discuss concerns. An observation on 07/08/2026 at 2:58 PM revealed an unknown staff member was walking through dining room during resident council meeting, was informed by the assistant activity director, We are having a meeting here. During an interview on 07/08/2026 at 3:05 PM with Assistant Activity Director revealed Resident Council had met in the main dining room about three times. About 26 members are in attendance. She stated they did what they can to make it a safe and quiet meeting. During an interview on 07/09/2026 at 4:14 PM with the ADMIN revealed there were alternative meeting locations in building that can provide privacy for monthly resident council meeting, such as the private dining room. Record Review of policy Resident Council revised April 2017 revealed facility supports residents' rights to organize and participate in Resident Council.		

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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 interviews and record review, the facility failed to implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, and mental and psychosocial needs in order attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 residents (Resident #89 and Resident #2) of 21 residents reviewed for care plans. The facility failed to correctly care plan Resident #89 advance directive as DNR. The facility failed to care plan Resident #2's primary diagnosis of dementia and primary language of Vietnamese. These failures could affect residents by placing them at risk of not receiving care and services to meet their needs and could deny a resident's end-of-life directive. Findings included: 1. Record review of Resident #89's MDS assessment revealed an [AGE] year-old male admitted to the facility on [DATE]. His BIMS score was 01 (severe cognitive impairment) with active diagnoses of Alzheimer's Disease, depression, chronic pain syndrome, and calculus of kidney. No active discharge plan for the resident to return to the community. Record review of Resident #89's Care Plan dated [DATE] revealed Resident/RP elected a FULL CODE Status. GOAL; Resident/RP wishes will be respected. Interventions/Tasks; Inform all Care givers of FULL CODE status. Notify MD and family as soon as possible begin CPR and call 911. Record review of Resident #89's Order summary Report dated [DATE] revealed DNR active [DATE]. Resident with hospice; diagnoses- senile degeneration of brain. Record review of Resident #89's Out-of-Hospital Do-Not-Resuscitate Order dated [DATE] revealed declaration by qualified relative signed. Two-witness completed by public notary and Physician's statement completed. 2. Record review of Resident #2's face sheet, dated [DATE], revealed a [AGE] year-old female, admitted with a primary diagnosis of unspecified dementia (cognitive decline with exact case unknown). Her primary language was Vietnamese. Record review of Resident #2's admission MDS, dated [DATE], revealed her BIMS interview was unable to be completed due to her advanced dementia. Her primary medical condition was determined Medically Complex Conditions with an ICD Code F03.90, (unspecified dementia). Resident #2's preferred language was Vietnamese. Record review of Resident #2's orders, dated [DATE], revealed on [DATE] she was prescribed Rexulti Oral Tablet 2 MG (Brexipiprazole). related to UNSPECIFIED DEMENTIA and to Monitor for the following behaviors: MEDICATION: REXULTI delusions, hallucinations, psychosis, aggression, refusal of care. Record review of Resident #2's care plan, dated [DATE], did not reflect a focus area or interventions related to her dementia diagnosis and her primary language of Vietnamese. During an observation and attempted interview on [DATE] at 3:08PM with Resident #2, she was in a squat like position, swaying her hands in a scooping like movement. An interview was attempted with Resident #2 but did not acknowledge she was being spoken too. At this time, CNA E attempted to assist Resident #2 into her geri chair and spoke in English to her. CNA E then utilized an electronic device to translate in Vietnamese to Resident #2 and was able to assist her into her geri chair. During an interview on [DATE] at 11:20 AM with LVN A, he said he provided care for Resident #2. Although her primary language was not English, LVN A said staff could say words in English to Resident #2, like medication and she was able to nod her head yes and take medications. LVN A said there were other staff that could communicate in Resident #2's primary language, if translation was needed, and there was a communication board in her room. LVN A said Resident #2 did not pay much attention to the communication board. LVN A said staff ensured care for residents, like Resident #2, with dementia by doing frequent checks at least every 2 hours, seeing if the residents' needs (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changed, or if they needed something like water. He said Resident #2 did take medication for her dementia. He said her diagnosis of dementia should have been care planned because residents with dementia needed more care, they needed reminders more often and could not do things for themselves anymore. He said the risk for not care planning dementia was things could happen, including dehydration, skin breakdown. He stated if abuse occurred, the resident may not be able to tell staff what happened. During an interview on [DATE] at 12:48 PM with the DON, he said Resident #2's dementia diagnosis and primary language of Vietnamese should be care planned. He said everything should be care planned because the state (Texas HHSC) said to and it was informational. He said the care plan was centralized communication specific to that resident. The DON said dementia should always be care planned for residents because they may have behaviors that described things like pain or stomach issues. He said dementia should be care planned for non-pharmacological interventions to help teach staff how to cope with the residents because if they were not understood by staff, it could lead to frustration or aggression. During an interview on [DATE] at 1:29 PM with the MDS Coordinator, she said care areas triggered in the MDS should be care planned. She said she did not realize Resident #2's dementia and primary language of Vietnamese were not care planned. The MDS coordinator said she would be responsible for care planning. The MDS coordinator said care planning the dementia and language were important, so staff knew how to take care of Resident #2. During an interview on [DATE] at 1:50 PM with CNA E, she said she knew Resident #2's primary language was Vietnamese because her family came to the facility often and she had gotten to know them. CNA E said the family spoke in Vietnamese to Resident #2 and it had seemed like she responded better to Vietnamese. She said she would speak to Resident #2 in English first when assisting or providing her care, and if English did not work she would then try Vietnamese with translation device. During an interview on [DATE] 3:10 PM with the ADON, she stated she was responsible for entering residents' advance directive status. She stated she entered Resident #89's advance directives by mistake. During an interview on 07/02/2026 4:14 PM with the ADM revealed, regarding advance directives, the ADON was the second check to ensure that the residents medical care preferences are respected. The risk to the resident was that their healthcare wishes were not respected. The ADM said residents with language barriers and dementia should have it in their care plans. The ADM said care plans were made by the nursing team and MDS coordinator.		