STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675882	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victoria Gardens of Allen	310 S Jupiter Allen, TX 75002

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 - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, and record reviews, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 9 rooms (Rooms 104, 105, 108, 209, 212, 306, 307, and 312) of 30 rooms reviewed for accident hazards. The facility failed to ensure the needle sharps containers (which are specialized receptacles designed to safely dispose of sharp medical instruments that can cause injuries or infections) in Rooms 104, 105, 108, 209, 212, 306, 307, and 312 were emptied.This failure could place residents at risk of being injured by a needle, and exposure to bloodborne pathogens. Findings included: Observation on 01/20/26 from 10:00 AM to 11:00 AM revealed all resident rooms have a sharps container mounted inside the resident room by the door. Rooms # 104, 105, 108, 209, 212, 306, 307, and 312, (which were occupied by residents) were noted to have been filled past the Fill line to the point the security flap could not operate. Interview on 01/20/26 at 11:25 AM, LVN A stated the nurses were responsible for replacing sharp containers when they filled to the Fill line on the container. He stated the risk of over filling the container was exposure to bloodborne pathogens from a used needle. Interview on 01/20/26 at 11:55 AM, the ADON stated the nurses were responsible for changing out the sharps containers, but all staff were responsible for monitoring the boxes and alerting the nurse when it needed to be changed. The ADON stated the risk of an over filled container was exposure to used needles which could cause an infection from pathogens on the needle. Interview on 01/20/26 at 2:50 PM, the DON stated she was not aware of the sharps containers being over filled. She stated the nurses and housekeeping both had keys to the boxes and either one could change out a full box. She stated the risk of an over filled container was bloodborne pathogen exposure from a used needle. Record review of the facility's Sharps Disposal, policy, dated January 2012, reflected: .3 c Designated individuals will be responsible for sealing and replacing containers when they are 75% to 80% full to protect employees from punctures and/or needlesticks when attempting to push sharps into the container.

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure resident records were maintained for each resident that were complete; accurately documented, readily accessible; and systematically organized for 1 of 9 residents (Resident #1) reviewed for resident records.LVN B failed to document a telephone order from the physician for Resident #1's cough medicine, guaifenesin.This failure could result in residents not receiving the medication ordered. Findings included:Record review of Resident #1's quarterly MDS, date [DATE], revealed she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included emphysema, lung cancer, end stage kidney disease requiring dialysis, and diabetes. Record review of Resident #1's care plan, dated [DATE], revealed she had a self-care deficit, had a tumor in her lungs, and went to dialysis every Monday, Wednesday, and Friday. Record review of Resident #1's EHR revealed the resident expired in the evening of [DATE] at the hospital. Record review of Resident #1's progress notes revealed on [DATE] she had a persistent cough. On [DATE], LVN B documented the resident was administered cough syrup for her cough.Record review on [DATE] of Resident #1's physician orders revealed no order for cough syrup. Interview on [DATE] at 2:40 PM, LVN B stated she had contacted Resident #1's nurse practitioner and received a verbal order for guaifenesin 10 ml every 4 hours as needed for cough on [DATE]. LVN B stated she administered the cough syrup immediately because the resident was coughing so severely. She stated she just forgot to enter the verbal order into the physician orders. LVN B stated the risk of not entering the order was the resident not receiving further doses of the medicine when she requested it, or a delay while another nurse called for the order again. Interview on [DATE] at 3:40 PM, the DON stated nurses were allowed to accept a verbal or phone order from the physician or their designee. The process for the nurse was to write the order down and repeat it back to the physician to ensure accuracy of the order. The nurse should ideally enter the order into the EMR and then read it back to the physician, but it was acceptable to enter the order before the end of their shift. The DON stated the risk of not entering the order was the resident not receiving the medication as prescribed and suffering the effects of not taking the medicine, and/or the resident receiving a medication without an order. Record review of the facility's Medication and Treatment Orders policy, dated [DATE], reflected: .2. Only authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record.3. Drug and biological orders must be recorded on the Physician's Order Sheet in the resident's chart. Such orders are reviewed by the consultant pharmacist on a monthly basis.7. Verbal orders must be recorded immediately in the residents' chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order.