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	04/14/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident had a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility for 1 of 4 residents (Resident #1 and Resident #2) reviewed for resident rights.The facility failed to ensure staff didn't tell Resident #1 to use her brief to go to the bathroom.This failure could place residents at risk of a decrease in quality of life.Findings include: Record review of Resident #1's face sheet, dated 04/14/26,ˆreflected an [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included cerebral infraction-unspecified (type of stroke caused by a blockage of blood flow to the brain), Dementia (is a syndrome characterized by a decline in cognitive function, affecting memory, thinking behavior, and the ability to perform every day activities), depression unspecified (a person exhibits depressive symptoms, but there is not enough information to assigns a more precise diagnosis), lack of coordination (muscle movements become clumsy, unsteady, or imprecise due to disruptions in the brain, nerves, or sensory systems., and urine retention (bladder doesn't empty completely).Record review of Resident #1's discharge MDS, dated [DATE], reflected her BIMS score was 14, which indicated no cognition impairment. Record review of Resident #1's care plan, dated 01/26/26, reflected Resident#1 was totally dependent in toilet use.Record review of Resident #2's face sheet, dated 04/14/26,ˆreflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included unspecified Dementia unspecified (is a syndrome characterized by a decline in cognitive function, affecting memory, thinking behavior, and the ability to perform everyday activities), depression Record review of Resident #2's discharge MDS, dated [DATE], reflected his BIMS score was 15, which indicated no cognition impairment. During an observation of video footage at 8:00 AM on 04/14/26, revealed CNA A went into Resident #1 and Resident #2's room, Resident #2 stated she needs to go to the bathroom. CNA A stated I can not take you right now because I can not pick you up Resident #2 stated the lady came in and said she would get assistance. CNA A stated I cannot pick you up by myself, that was the nurse. The nurse cannot do it right now; she has to pass meds. CNA stated you have a diaper, its nothing we can do. If I accidently drop you. [Resident # 1 was heard crying at this point]. CNA stated You got to wait, If you got to go just go, go in your pants and we will clean it up, it take people to help pick you up, we have to be safe; it's nothing I can do right now but see if somebody will come with me.CNA walked out of the room and returned with a meal tray. I got to ask them I am new here today. Resident#1 stated I wet the bed CNA A stated You wet the bed? Resident #1 stated Right now. Resident #2 stated sorry honey.I talked to 2 to 3 people and they said they would come back and they didn't. CNA A stated the other 3 should have done it. Footage showed CNA A walk out of the room, Resident #2 stated I know honey, I'm sorry. Resident #2 was seen walking out of the roomDuring an interview on 04/14/26 at 8:45 AM, CNA F stated nursing staff should try to assist the residents as soon as possible. CNA F stated residents should never be told to have a bowel movement in their brief. CNA F stated the residents are human and deserved to be treated with respect and integrity. During an interview on (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/14/26 at 9:00 AM, CNA D stated it was never ok to tell a resident to have a bowl movement or urinate in their brief. If you need assistance get help from another staff as soon as possible.During an interview on 04/14/26 at 9:05 AM, CNA E stated nursing staff should change the resident as soon as possible. It is their right to be able to go to the bathroom and not in their brief.During an interview on 04/14/26 at 9:15 AM, the DON, ADON B and ADON C viewed the video footage and identified the staff member as CNA A who was from agency. The DON stated staff should never tell a resident to urinate in their brief because that is a dignity concern. The DON stated nursing staff should work together to assist the resident with their needs. Attempted a phone interview with CNA A on 04/14/26 at 9:38 AM, was unsuccessful and left voicemail.During observation and interview on 04/14/26 at 4:00 PM, the Admin, DON and ADON B reviewed video footage again. ADON B and DON stated residents not being changed when asked and told to use it in their brief was a resident rights issue. ADON B stated nursing staff During an interview on 04/16/26 at 8:34 PM, over the phone CNA A stated that was the first time she had worked at the facility with Resident #1 and Resident #2. CNA A stated she did not feel comfortable toileting residents on her own. CNA A stated she did not mind changing the residents. CNA A stated she never told a resident to urinate in their brief. CNA A stated that was not the right thing to do and she did not mind changing the resident. CNA A stated residents wanted to feel as human as possible, and it was a dignity issue not to provide toileting care when asked. Record review of the facility admission agreement, undated reflected. G. Services Provided.Assistance and/or supervision when required with activities of daily living, including but not limited to, toileting, bathing, feeding and ambulation assistance.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and interview the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls, permitted only authorized personnel to have access to the for 2 (MC#1 and TC#2) of 3 carts on 04/14/26.This failure could place residents at risk of drug diversion. Findings include:During an observation on 04/14/26 at 6:45 AM, it was revealed that the medication cart was left unlocked with the drawer facing outward at the nursing station. Surveyor did not observed staff at the nursing station or within view of Medication Cart#1 and Treatment Cart#2. Surveyor observed that Treatment Cart#2 was unlocked and was adjacent from the nursing station with the drawer's facing outward toward the hallway.During an interview on 04/14/26 at 7:00 AM, LVN G stated he had an emergency and stepped away from the medication cart. LVN G stated the treatment cart stayed unlocked for emergencies. LVN G stated residents with Dementia could take medication from the medication cart and it needed to be locked.During an interview on 04/14/26 at 7:10 AM, RN H stated the medication cart needed to be locked at all times, because residents or visitors could get into the cart and take medications. LVN H stated the nurse who was on the cart that day was responsible for making sure the cart was locked.During an observation on 04/14/26 at 9:40 AM surveyor observed the inside of Treatment Cart#2 which included:4 X Sterile water, USP 500 ML2 X Thera honey Gel, 05 OZ tube1 x Zinc oxide paste - 4 OZ4 x Hydrophilic wound dressing - 71 G3 X Skin Integrity Hydrogel- 4 OZ3 x Hydrogen Peroxide topical solution USP 946 ML During an interview on 04/14/26 at 4:00 PM, the DON stated each nurse was responsible for making sure their medication cart and treatment cart were locked. The DON stated even if the medication cart was at the nursing station the cart should be locked to prevent residents from taking medications from the cart and taking them resulting in a adverse reaction. Surveyor exited without medication/treatment cart secure policy.