

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675882	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2026
NAME OF PROVIDER OR SUPPLIER Victoria Gardens of Allen		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure all Pre-admission Screening and Resident Review (PASRR) level 1 residents with mental illness were provided with a PASRR level 2 evaluation for 1 of 2 residents (Resident #8), reviewed for resident assessment. Resident #8's PASRR level 1 screening form did not reflect mental illness, and the resident did not have a PASRR level II evaluation. This could place residents at risk of not receiving necessary specialized services to meet their individual needs. The findings were: Record review of Resident #8's quarterly MDS assessment, dated 01/15/2026, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's BIMS score was 15 indicating the resident's cognition was intact. Her diagnoses included Bipolar Disorder (mental condition marked by alternating periods of elation and depression), Generalized Anxiety Disorder (disorder characterized by feelings of worry, anxiety, or fear that are enough to interfere with one's daily activities), Post Traumatic Stress Disorder (a mental health condition that's caused by an extremely stressful or terrifying event) and Insomnia (trouble falling and/or staying asleep). Record review of Resident #8's Care Plans reflected: 06/17/2025: The resident was receiving Behavioral Health services to assist with her diagnosis of PTSD, Anxiety, and Mood Disorder. 06/17/2025: The resident had behaviors such as crying, excessive worry, irritability, and paranoia. Record review of Resident #8's PASRR level 1 screening, dated 09/06/2024 reflected the resident did not have a serious mental illness and serious mental illness was checked as no. An interview on 02/11/2026 at 3:35 PM with MDS Nurse A revealed she did not know why Resident #8 had a negative PASRR level 1 screening. She said the resident's PASRR was completed by the hospital and not checked for accuracy when the resident was admitted. MDS Nurse A stated she was responsible for ensuring that PASRRs were correct. MDS Nurse A stated an inaccurate PASRR could result in the facility not knowing what services the Resident would need to meet her needs. Review of the facility policy, PASRR Rules and Guidelines, dated 01/09/2026, reflected: The intent of this guideline is to identify residents with Mental Illness (MI), Intellectual Disability (ID) or Developmental Disability (DD)/Related Conditions (RC) and to ensure they are properly placed, whether in community or in a Nursing Facility (NF) and to ensure they receive the services they require for their MI, or ID/DD. The facility Business Development Specialist (BDS) or designee will coordinate with the referring entity to ensure that a PASRR Level 1 (PL1) screening is completed.		

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure that a resident receives treatment and care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for one (Resident #95) of four residents reviewed for quality of care. The facility failed to ensure RN I completed wound cares to Resident #95 per physician orders. This failure placed residents at risk for the decline in quality of life and the wounds being infected or deteriorating. Review of Resident #95's face sheet dated 02/11/26 revealed he was a [AGE] year-old male, and he was admitted on [DATE]. Admitting diagnoses included, type 2 diabetes, acquired abscess of the left toe, peripheral vascular disease, and chronic osteomyelitis (Reduced blood flow (ischemia) from narrowed arteries limits immune response) left ankle and foot. Review of Resident #95's admission MDS assessment dated [DATE] reflected he had a BIMS score of 15, indicating no cognitive impairment. The resident had orthopedic aftercare following surgical amputation. Review of Resident #95's care plan initiated 02/05/26 reflected, Resident #95 had a partial amputation of left 3rd toe related to diabetes. The goal was for Resident #95's wound to heal and progress without complications. Intervention was to check and document on wound daily for sign and symptoms of infection, drainage, bleeding, any breakdown of skin and impaired circulation (edema (swelling) or pain). Resident #95 had diabetic ulcer of the left plantar foot related to diabetes. The goal was that the resident will have no complications related to ulcer. Intervention was for weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (discharge) and any other notable changes or observations. Review of Resident #95's physician summary dated 02/11/26 reflected an order dated 02/06/26 left 3rd toe: clean with normal saline wound cleanser and paint with betadine (antiseptic used to kill bacteria, fungi, and viruses) and apply adaptic (non-adhering wound dressing) and cover with gauze daily and as needed if soiled or dislodged one time a day for wound care. Left foot plantar: clean with normal saline pat dry, apply collagen powder, cover with foam padding, and wrap with kerlix (gauze bandage rolls) then secure with tape one time a day for wound care. Observation and interview on 02/09/26 at 11:18 AM with Resident #95 reflected the resident was in the wheelchair. The resident was noted with wound dressings to the third left toe. In an interview with Resident #95 he stated his wound care was not completed on the weekend (02/07/26 and 02/08/26). The resident stated wound care had been completed on 02/09/26 in the morning. He stated he was not aware of the state of the wounds. Observation and interview on 02/10/26 at 10:20 AM with Resident #95 during wound care revealed no signs or symptoms of infection to the wounds. The resident denied pain during wound care. In an interview on 02/10/26 at 12:40 PM LVN G revealed she was the treatment nurse, and she completed all wound cares in the facility on Monday through Friday and the charge nurses would complete the wound cares on Saturday and Sunday. LVN G stated that when she was completing wound care to Resident #95, the resident reported his wound care was not completed on the weekend. There were no signs or symptoms of infection to the wounds. LVN G reported to ADON the residents' concerns. In an interview on 02/11/26 at 12:25 PM with LVN H, she revealed she was an ADON. She stated the treatment nurse (LVN G) reported that Resident #95's wound care was not completed over the weekend. LVN H spoke with the resident regarding the concern with the wound care not provided. LVN H stated she tried to talk with the weekend nurse, and she could not get hold of the nurse until today in the morning. LVN H stated the weekend charge nurse reported he had signed the EMAR and when he went to the room the resident was not there, and he did not go back to do the wound care. LVN H stated the weekend charge nurse was expected to complete wound care per the physician orders and failure could cause wound infection or wounds getting worse. In an interview on 02/11/2026 at 2:24 PM RN I revealed he was the weekend charge nurse for Resident #95 on 02/07/26 and 02/08/26. He stated he did not complete the wound care because on Saturday (02/07/26) it (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	skipped his mind and on Sunday (02/08/26) the resident was out on pass, and he saw the resident around dinner time, and he forgot to go back and complete the wound care. RN I stated wound cares were to be completed to prevent the wounds from deteriorating and getting infected. In an interview on 02/11/26 at 3:20 PM with the DON she stated she was not aware that wound care was not completed over the weekend until the ADON reported. The DON stated RN I was expected to complete Resident #95 wound care per the physician orders. The treatment nurse and the ADONs were responsible for making sure the wound cares were completed. Review of the facility policy revised November 2017 and titled Wound Care reflected, . The purpose of this procedure is to provide guidelines for the care of wounds to promote healing.The policy did not have information about providing wound care.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for one of six residents (Resident #75) observed for infection control. The facility failed to ensure CNA D completed hand hygiene while providing incontinence care to Resident # 75. This failure could place the residents at risk of infection. Record review of Resident #75's face sheet dated 02/11/26 reflected a [AGE] year-old female. She was admitted to the facility 01/14/26. Admitting diagnoses included hypertension, pressure ulcer to the sacrum area (located at the base of the spine) muscle weakness, neuromuscular dysfunction of the bladder (person lacks bladder control) and muscle wasting and atrophy. Review of Resident #75's care plan initiated 01/14/26 reflected Resident #75 had bowel/bladder incontinence related to disease process, impaired mobility and neurogenic disorder (conditions that target how your nervous system). Goal, the resident will remain free from skin breakdown due to incontinence and brief use. Review of Resident #75's admission MDS record dated 01/20/26 reflected that the resident had a Brief Interview of Mental Status score of 14, indicative of no cognitive impairment. Resident #75 required assistance with toileting. In an observation on 02/09/26 at 1:29 PM during incontinent care CNA D provided incontinent care to Resident #75. The resident was soiled with urine and feces, and after CNA D cleaned the resident, she did not complete any form of hand hygiene or change gloves. With the same dirty gloves CNA D applied the clean brief on the resident. In an interview on 02/10/2026 at 1:55 PM with CNA D she stated she was not aware if she was supposed to change gloves and complete hand hygiene after cleaning the resident and she stated she did not have answers to the questions the surveyor was asking her. CNA D stated she did not think she needed to wash hands after changing the resident if she changed gloves. CNA D stated she was supposed to complete hand hygiene and change gloves to prevent transmission of infection. CNA D stated she was in the process of completing the infection training online. In an interview on 02/11/2026 at 11:40 AM LVN E revealed she was the infection preventionist. LVN E stated she had verbally in-serviced all nursing staff including CNA D on infection control. LVN E stated CNA D was expected to maintain infection control while providing incontinent care by completing hand hygiene and changing gloves after cleaning the resident. Hand hygiene was required to prevent transmission of infections. In an interview and record review on 02/11/2026 at 3:57 PM with the DON she stated her expectation was for the staff to maintain infection control while providing care to residents. The DON stated CNA D was to complete hand hygiene and change gloves after cleaning the resident, before applying the clean brief. The DON stated CNA D had been in-serviced on infection control on 02/10/26. The DON provided record of the in-service and it reflected CNA D had been in-serviced. The DON stated the staff was to maintain infection control to prevent the transmission of infections. Review of the facility policy revised December 22, 23 and titled Hand Washing/Hand Hygiene reflected, The facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread on infections to other personnel, residents and visitors. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with hand hygiene is recognized as the best practice for preventing healthcare-associated infection.		