

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: 676358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER The Villages on MacArthur		STREET ADDRESS, CITY, STATE, ZIP CODE 3443 N MacArthur Blvd Irving, TX 75062	
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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to protect the confidentiality of personal and medical records for 7 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7) of 8 residents observed for personal privacy and confidentiality of records.1. The facility failed to ensure the confidentiality of Resident #1's health information when there was a posted sign that reflected, Feeder on Resident #1's door on 06/06/26.2. The facility failed to ensure that the lunch meal tickets for 6 (Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7) of 6 residents on the 700 Hall were not in view of the public on 07/29/26. These failures could affect residents by placing them at risk for loss of privacy and dignity. The findings included: During a telephone interview on 07/29/26 at 10:06 AM, with the FM of Resident #1, she stated the resident was at the facility for 4 years. The FM stated she was the RP of Resident #1 and was the resident's POA due to the resident being diagnosed with dementia (a decline in mental ability severe enough to interfere with daily life), and Alzheimer's. The FM stated Resident #1 had a private room during his stay at the facility. The FM stated she visited Resident #1 at the facility at least 3-4 times per week. The FM stated on 06/06/26, she visited Resident #1 at the facility and upon approaching Resident #1's door, there was a white paper posted on the door with green writing with the word, Feeder. The FM stated the posted sign was taped on Resident #1's door. The FM stated she spoke with LVN D at the nurses station and she showed her the posted Feeder sign that was on Resident #1's door. The FM stated LVN D removed the posted Feeder sign that was on Resident #1's door. The FM stated she told LVN D that the posted sign on Resident #1's door was very demeaning and degrading and she did not like the sign on the door and she wanted to ensure Resident #1's had dignity and some privacy due to the resident already being a resident at the facility. The FM stated she did not file a grievance with the Social Worker at the facility regarding the posted Feeder sign being on Resident #1's door. The FM stated she did not file a Grievance due to LVN D removing the Feeder sign on Resident #1's door. Record review of a time and date stamped screenshot received via text message from Resident #1's FM revealed a photograph of Resident #1's door with Resident #1's name beside the door. The screenshot revealed that the photograph was taken on 06/06/26 at 8:28 PM. The photo revealed there was a posted Feeder sign on the front of Resident #1's door with tape. The Feeder sign was a white piece of paper with the word, Feeder in green writing and was on the front of Resident #1's door. Observation of the facility's 700 Hall on 08/06/26 at 12:25 PM, revealed there were 6 lunch meal tickets observed posted behind the name plate of 2 (Resident #5 and Resident #6) residents room. The lunch meal tickets were for 6 residents which included Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7. The observation of the residents meal tickets revealed that the information for each resident included the residents name, room number and dietary notes with special instructions. The 6 resident meal tickets (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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