STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676483	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ventana by Buckner	8301 N. Central Expressway Dallas, TX 75201

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observations, interviews, and record review, the facility failed to make information on how to file a grievance or complaint available t the resident for 2 of 2 confidential residents reviewed for grievances. The facility failed to notify residents or their representatives either individually or through prominent postings throughout the facility on how to file a grievance or complaint in an anonymous manner.These failures could affect resident's ability to file a grievance without the fear of discrimination, reprisal, retribution, and their right to anonymously file their grievance.Findings included:Observation on 03/16/26 at 2:45 PM revealed there were no grievance forms available in any common areas nor indications of places to find grievance forms. Interview on an undisclosed date and time with six confidential residents revealed the residents were unaware where grievance forms were located. The residents stated that they did not know how to anonymously file a grievance. Interview on 3/16/26 at 11am with Resident #33's representative expressed concerns about how many times the staff come and go out of the resident's room asking the same questions and delegating resident #33 requests to other staff members. Interview on 3/16/26 at 11:15am with Resident #66 expressed concerns about care but was unaware of grievance forms. Confidential residents expressed if they needed to know how to fill out an anonymous grievance. Interview on 3/18/26 at 12:00 noon with CNA D who has worked at this facility for three years. CNA D stated if a resident or family wants to fill out a grievance report she would tell an Administrator. CNA D stated there are no grievance forms available. CNA stated if a resident or family member are wanting to file an anonymous grievance CNA D would call an Administrator. Interview on 3/18/26 at 2pm with SW who stated if a family or resident informs the SW they want to fill out a grievance, the SW will assist them. If SW is not available, the resident or family would go to ADON to fill out the grievance. If the resident or family wanted to fill out a grievance anonymously, the SW said there might be grievance forms at the nurse's station for the resident or family to use. If grievance forms are unavailable for the resident or family to fill out anonymously a resident or family member would feel they do not have a way to express their concerns. Interview on 03/18/26 at 4:23pm with DON, she stated that she did not know that there needed to be a system in place for residents to have a way to file a Grievance anonymously. She stated that residents can file a Grievance with the Social Worker or any staff member. She stated that there was a potential risk for possible harm if a resident did not have a way to file a grievance anonymously. The DON stated potential harm included someone feeling scared to say anything about a staff member, which could lead to retaliation.Review of the facility's policy titled, Grievances dated revised October 21, 2025, revealed that the Residents and/or families may submit complaints or suggestions to the Grievance Official, department head or Executive Director.Complaints or suggestions are directed to the designated Grievances Official. The [facility] will respond and investigate all grievances and complaints within the community. Review of the Code of Federal Regulations Resident's Rights subsection Grievances revealed.The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The facility must make information on how to file a grievance or complaint available to the residents.Record review of the facility's Grievance policy revealed no information about the submission of grievances being completed and submitted anonymously.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 1 (300 Hall) out of 2 hallways reviewed for accidents and hazards. 1.The facility failed to ensure that the mechanical lift in Resident #58's bathroom on 300 Hall was locked and secured when not in use. This failure could place residents at risk of falls and/or injuries.Findings Included:Record review of Resident #58's admission face sheet dated 03/18/26 reflected she was a [AGE] year-old female admitted to the facility on [DATE] with active diagnoses that included: dementia, hypertension (high blood pressure), displ commnt fx shaft or l femr (displaced, comminuted fracture of the shaft of the left femur), osteoarthritis (chronic joint disease, characterized by the gradual breakdown of protective cartilage that cushions the ends of bones), metabolic encephalopathy (a syndrome of global brain dysfunction caused by chemical imbalances, toxins, or systemic illness rather than structural brain damage), Afib (the most common type of treated heart arrhythmia, characterized by a rapid, irregular heartbeat caused by chaotic electrical signals in the heart's upper chambers (atria), arteriosclerosis heart disease of native coronary artery w/o chest pain (heart disease from plaque buildup in the coronary arteries without chest pain), metabolic encephalopathy (a broad term for brain dysfunction caused by underlying systemic illnesses-such as organ failure, infections, or chemical imbalances-that deprive the brain of energy or create toxic environments), and hearing loss. Record review of Resident #58's Quarterly MDS assessment dated [DATE], reflected a BIMS score of 06 indicating severe cognitive impairment. Resident #58's MDS Assessment reflected she was incontinent and required total assistance with ADL Care and received hospice services. Record review of Resident #58's Care Plan dated 01/26/2026 reflected,Problems: [Resident #58] had a history of falls on 12/10/25 and 12/29/25, since her admission to the facility. Goals:[Resident #58] will maintain current level of mobility with no increase in the incidence of falls/injuries over the next 90 days.Interventions:Assist [Resident #58] to wear non-stick footwear that fits.Engage [Resident #58] in activities that improve strength, balance, and posture as tolerated and document results.Instruct [Resident #58] on safety measures to reduce the risk of falls use of handrails.Keep areas free of obstructions to reduce the risk of falls or injury to [Resident #58]. In an observation and interview with Resident #58 on 03/16/26 at 11:13 AM was alert and was watching television while lying in bed. Resident #58's bed was observed in a low position. Resident #58 was observed wearing non-slip socks. Resident #58 stated that the mechanical lift in her bathroom had been in her room for a while. Resident #58 was unable to confirm how long the mechanical lift had been in her bathroom. Resident #58 stated that the staff use the mechanical lift when they give her a bath. Resident #58 was unable to differentiate which staff used the mechanical lift. Resident #58 did know how many staff members use the mechanical lift when it was in use. Resident #58 was unable to confirm or deny if she had any falls since her admission to the facility. Observation of Resident #58's room on 03/16/26 at 11:17 AM revealed an unlocked and unsecured mechanical lift parked inside of the doorway inside of the bathroom entry. Observation of Resident #58's room on 03/16/26 at 2:46 PM revealed an unlocked and unsecured mechanical lift parked inside of the doorway inside of the bathroom Observation of Resident #58's room on 03/17/26 at 10:15 AM revealed an unlocked and unsecured mechanical lift parked inside of the doorway inside of the bathroom. Observation of Resident #58's room on 03/17/26 at 3:50 PM revealed an unlocked and unsecured mechanical lift parked inside of the doorway inside of the bathroom. Observation of Resident #58's room on 03/18/26 at 10:30 AM revealed an unlocked and unsecured mechanical lift parked inside of the doorway inside of the bathroom. In an interview on 3/18/26 at 10:35 AM with LVN A, she stated that there were not any mechanical lifts in any resident's room on the 300 hall. Observation of Resident #58's room on 03/18/26 at 10:43 AM revealed an unlocked and unsecured (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mechanical lift parked inside of the doorway inside of the bathroom. In an interview on 3/18/26 at 11:05 AM with LVN A, she stated that she had been employed at the facility since August 2025. LVN A stated that she was assigned to the 300 hall where Resident #58 resided. She stated that she was unaware that the mechanical lift in Resident #58's bathroom was unlocked. She stated that the facility did not provide the mechanical lift in Resident #58's bathroom. LVN A stated that the mechanical lift in Resident #58's bathroom was provided by the resident's hospice care agency. LVN A stated that she had observed the mechanical lift in Resident #58's bathroom on several occasions. She stated that the mechanical lift in Resident #58's bathroom is used by the hospice nurse when patient care is being provided to Resident #58. LVN A stated that she had not used the mechanical lift in Resident #58's bathroom. LVN A stated that she had not observed any staff operate and use the mechanical lift for patient care for Resident #58. LVN A stated that she was unaware that mechanical lifts needed to be locked in the bathroom area when not in use. She stated that she had taken In-Service Trainings on Hoyer and Mechanical Lift usage and safety. LVN A stated that she could not recall when she had previously taken In-Service Trainings on Hoyer and Mechanical Lift usage and safety. LVN A stated that mechanical lifts should always be locked in the common areas, such as the hallways when they are not being used. LVN A stated that harm could be caused to anyone when a mechanical lift is unlocked. She stated that someone could break a body part, such as an arm or leg when a mechanical lift is unlocked. In an interview on 3/18/26 at 11:12 AM with CNA B, she stated that she had been employed at the facility for 1 month. CNA B stated that she was assigned to the 300 hall where Resident #58 resided. She stated that she was unaware that the mechanical lift in Resident #58's bathroom was unlocked. CNA B stated that she had observed the mechanical lift in Resident #58's bathroom on several occasions when she had done patient care for her. CNA B stated that she had never checked to confirm if the mechanical lift in Resident #58's bathroom was locked or unlocked. CNA B stated that she had not used the mechanical lift in Resident #58's bathroom. CNA B stated that she had not observed anyone use the mechanical lift in Resident #58's bathroom. She stated that she had taken previous In-Service Trainings on mechanical lift safety and usage. CNA B stated that she could not recall when she took her last In-Service Trainings on mechanical lift usage and safety. CNA B stated that harm could be caused to a resident or anyone that enters the bathroom when a mechanical lift is unlocked. She stated that someone could be harmed depending on their fall and receive a head injury or broken bones. An email was sent to the Administrator on 03/18/26 at 12:31 PM, requested the facility's policy on accidents and hazards. An attempted telephone call to Resident #58's POA was unsuccessful on 03/18/26 at 3:02 PM. In an interview with the DON on 03/18/26 at 4:15 PM, she stated that she had been employed at the facility for 2 years. The DON stated that she was unaware that the mechanical lift in Resident #58's bathroom was parked and was observed unlocked and unsecured on 03/16/26, 03/17/26 and 03/18/26. The DON stated that the mechanical lift in Resident #58's room was provided by the resident's hospice care agency. She stated that Resident #58 often refuses care and the mechanical lift is not used by her staff on the resident. The DON stated that her expectation is that all mechanical lifts are to be locked when they are not being used. The DON stated that all staff have been educated and trained on the proper usage and safety of mechanical lifts. The DON stated that she could not recall when the staff received their last In-Service Training on mechanical lifts. She stated that she will reeducate staff with In-Service training on Mechanical Lifts and Mechanical Lift Storage and Safety. She stated that there was a risk to anyone to be injured due to an unlocked and unsecured mechanical lift. The DON stated that there was potential for harm to anyone who attempted to pull themselves up using an unlocked and unsecured mechanical lift, which can cause injuries. The DON stated that the facility did not have any policies regarding mechanical lifts and accidents and hazards. In an interview with RN G on 03/18/26 at 4:25 PM, she stated that she was the Hospice Nurse for Resident #58. RN G stated that she had several residents that she visited at the facility on her schedule. She stated that Resident #58 has dementia and received hospice services. RN G stated that Resident #58's memory will go in and out, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meaning that some days she will remember something and other days, she will have total memory loss. RN G stated that she did not know if the hospice care agency for Resident #58 provided the mechanical lift that was currently in the resident's room. RN G stated that she did not use the mechanical lift for Resident #58. RN G stated on several occasions, she observed the CNAs use the mechanical lift in Resident #58's bathroom for patient care. RN G stated that she was unaware that the mechanical lift in Resident #58's bathroom remained unlocked for 3 days. RN G stated that mechanical lifts should always be locked when they are not in use to prevent injuries. Record Review of facility's policies for Mechanical Lift Transfer, Safe Handling, and Care of Community Property. did not provide any information regarding accidents and hazards relating to mechanical lifts.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders for 1 of 3 (Resident #90) residents reviewed for parenteral fluids. The facility did not ensure Resident #90's midline dressing was changed per the physician orders. This failure could place residents at risk for receiving care that is not safe and at risk for infectionReview of Resident #90's face sheet dated 03/18/26 reflected she was a [AGE] year old female, and she was admitted to the facility on [DATE]. Admitting diagnoses included, pressure-induced deep tissue damage of left heel, dementia, chronic ulcer of heel and midfoot. Review of Resident #90's care plan dated 03/18/26 reflected the resident had a midline (IV catheter is a peripheral vascular access device inserted into a vein in the upper arm, with the tip located near the axilla, suitable for short- to moderate-term intravenous therapy.) Review of Resident #90's physician order dated 03/18/26 reflected an order dated 03/01/26 indicated to change central line/midline dressing every seven days. Observation on 03/18/26 at 01:46 PM revealed Resident #90 was in the wheelchair, and she had a midline line to the upper left arm and the dressing was dated 3/5/26. Resident #90 was not interieweble. In an interview on 03/18/26 at 02:14 PM with LVN E she stated she was not sure when the midline dressing was supposed to be changed. She stated the resident had a midline and dressing needed to be changed per the orders to keep the midline in place and to prevent infection. In an interview on 03/18/2026 at 2:24 PM with the DON she stated there were three residents in the facility with midlines. The DON stated she expected the midline dressing to be changed once weekly (every 7 days) and as needed and per the physician orders. She stated that the charge nurses were responsible for completing the midline dressing changes. The DON stated there was no assigned staff who was responsible for checking to make sure the midline dressing was changed timely. The DON stated the midline dressing was to be changed to prevent infection. In an interview on 03/18/2026 at 3:26 PM with ADON revealed she was the infection preventionist. She stated she was informed by the DON that Resident #90's midline dressing had not been changed. The ADON stated, she expected the charge nurse to complete midline dressing by physician order and facility policy (every seven days) to prevent infection. Review of facility policy dated 10/21/25 and titled PICC line reflected, . 4. An RN will normally provide dressing changes as needed and as ordered; however, an LVN can change the PICC line dressing so long as there is documented training and skills competence check off on file. This is the only policy provided by the facility, the DON indicated the facility did not have any other policy on midline IV dressing change.