STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455653	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Nursing Center	3326 Burgoyne Dallas, TX 75233

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to provide the necessary services for residents who were unable to carry out activities of daily living to maintain good grooming and personal hygiene for 2 residents (Resident#1 and #Resident #2) of 6 residents reviewed for ADLs. The facility failed to ensure: 1. Resident #1 had his fingernails cleaned and trimmed on 08/06/25.2. Resident #2 had her fingernails cleaned and trimmed on 08/06/25.These failures could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, and a decreased quality of life.1. Record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected Resident #1 was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included hypertension (elevated blood pressure), cerebrovascular accident (Occurs when blood flow to the brain is interrupted, leading to brain cell death and potential neurological damage) muscle weakness, and dementia (diseases that affect memory, thinking, and the ability to perform daily activities). Resident #1 had a BIMS score of 5, which indicated severe cognitive impairment. The MDS assessment indicated Resident #1 required partial/moderate assistance with personal hygiene. Record review of Resident #1's Care Plan dated 06/06/25, reflected the following: Focus: [Resident#1] has an ADL selfcare performance deficit related to impaired balance, stroke. Goal: [Resident#1] will improve current level of function in . personal hygiene through the review date. Interventions: Personal hygiene.the Resident requires (1) staff participation with personal hygiene .In an observation and interview on 08/06/25 at 10:04 AM Resident #1 was lying in his bed. Resident #1's nails on both hands were approximately 0.4 cm in length extending from the tip of his fingers, and jagged. The nails were discolored tan with black matter underneath. Resident #1 stated he would like his fingernails trimmed and cleaned. In an interview on 08/06/25 at 10:38 AM CNA A looked at Resident #1's fingernails and stated they were dirty. CNA A stated residents' fingernails were supposed to be cleaned on shower days. CNA A stated Resident #1's shower schedule was Mondays, Wednesdays, Fridays in the morning. CNA A could not say if Resident #1 had a shower last Monday (0804/25). CNA A stated that both CNAs and Nurses were responsible for nailcare. He said that if Residents has diabetes, then nurses trimmed their fingernails. He stated that if nails were long and dirty, residents may be at risk of infection. 2. Record review of Resident #2's Quarterly MDS assessment dated [DATE] reflected Resident #2 was a [AGE] year-old female with initial admission date to the facility on [DATE], and readmission on [DATE]. Resident #2's diagnoses included Hypertension (elevated blood pressure), type 2 diabetes (elevated blood sugar), muscle wasting and atrophy (the decrease in size or wasting away of a body part, such as muscle or tissue, due to cell shrinkage or cell death), and dementia (diseases that affect memory, thinking, and the ability to perform daily activities). Resident #2 had BIMS score of 14 which indicated intact cognition. Resident #2 was dependent on the staff for personal hygiene. Record review of Resident #2's Comprehensive Care Plan revised on 07/16/25 reflected, Focus: [Resident #2] has an ADL Self Care, Performance Deficit related to deconditioning activity intolerance, fatigue, Impaired balance. Goal: [Resident #2] will improve current level of function in all ADLs through the review date. Intervention: PERSONAL HYGIENE/ORAL CARE: [Resident #2] is dependent with personal hygiene.In an observation and interview on 08/06/25 at 11:05 AM Resident #2 was up lying in bed. The resident's nails on both hands were approximately 0.6 cm in length extending from the tip of her fingers. The nails were discolored tan and had brown colored residue underneath. Resident #2 stated she wanted her fingernails cleaned and trimmed. In an interview and observation on 08/06/25 at 11:21 AM CNA B looked at Resident #2's fingernails and stated she would clean and trim them today. She stated that fingernails should be trimmed and cleaned on shower days and as needed. She stated that Resident #2 had dirty, untrimmed fingernails. She stated that dirty nails could lead to infections. In an interview on 08/06/25 at 2:45 PM, the DON stated nail care should be completed as needed and every time aides washed the residents' hands. The DON stated nails should be observed daily. The DON stated nurses were responsible for trimming the nails of residents who were diabetic, and CNAs could trim other residents' nails. The DON stated she expected CNAs to offer to cut and clean nails if they were long and dirty. The DON stated the ADON, and the DON would do the routine rounds to monitor. The DON stated residents having long and dirty fingernails could be an infection control issue. In an Interview on 08/06/25 at 3:39 PM, the Administrator stated nail care should be completed during the shower days. He stated the activities staff participated in nails care for the residents. He stated nail care was the responsibility of the clinical care staffs, CNAs and

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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 establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 6 residents (Resident #3) reviewed for infection control. The facility failed to ensure CNA A performed hand hygiene while providing incontinence care to Resident #3 on 08/06/25. These failures could place residents at risk of cross-contamination and development of infections. Record review of Resident #3's annual MDS assessment dated [DATE] reflected Resident #3 was an [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included hypertension (elevated blood pressure), neurogenic bladder (a problem in the brain, spinal cord, or central nervous system that make a person lose control of the bladder) muscle weakness, dementia (diseases that affect memory, thinking, and the ability to perform daily activities), and lack of coordination. Resident #3 had a BIMS score of 5, which indicated severe cognitive impairment. The MDS assessment indicated Resident #3 required substantial/maximal assistance with personal hygiene. Record review of Resident #3's Care Plan dated 06/02/25, reflected the following: Focus: [Resident#3] has an ADL selfcare performance deficit related to dementia. Goal: [Resident#3] maintain current level of function in . personal hygiene through the review date. Interventions: Personal hygiene. [Resident#3] requires extensive assistance with personal hygiene .Observation on 08/06/25 at 10:27 AM revealed CNA A entered Resident #3's room to help him change his clothes. Resident #3's pants were wet with urine. CNA A put on gloves without performing any form of hand hygiene. CNA A got a pull up brief, and Resident #3's clean short pants ready at the foot of the bed. CNA A helped Resident #3 to standing position. CNA A removed Resident #3's wet pants and pulled up the brief. CNA A changed gloves without performing any form of hand hygiene. CNA A put a clean pull up brief, and clean short pants on Resident #3, and pulled them up to Resident #3's knees. CNA A cleaned Resident #3's private area front to back with wipes and pulled the brief and shirt up without changing gloves and performing hand hygiene. CNA A helped Resident #3 to sit in his wheelchair and put on his shoes. CNA A changed gloves without any form of hand hygiene and proceeded to help Resident #3's roommate. In an interview on 08/06/25 at 10:38 AM, CNA A stated he should perform hand hygiene before putting on clean gloves, and anytime he changed gloves. CNA A stated he should change gloves with hand hygiene when he went from dirty to clean. CNA A stated failing to follow proper hand hygiene, and gloves use could expose the resident to infections. In an interview on 08/06/25 at 2:46 PM, the DON stated they trained at length on when staff were to change their gloves and sanitize their hands. She stated staff needed to perform hand hygiene upon entering the resident's room, and each time they changed gloves. She stated staff needed to change their gloves with hand hygiene when they went from dirty to clean. She stated the risk was increased risk of infections. She stated she and the ADON would be doing a one-to-one re-training and observing care to ensure staff compliance. Record review of the facility's policy, Perineal Care, dated June 2020, reflected Wash hands . Put on gloves .Wash the penis .Wash the scrotum .Turn the resident on side .wash, rinse and dry buttocks and peri-anal area without contaminating perineal area .Remove gloves. Wash hands or use alcohol-based sanitizer .Note: Do not touch anything with soiled gloves after procedure (example: curtain, side rails, clean linens , call bell,) .put on clean gloves .Clean and return all equipment to its proper place .Place soiled linen in proper container .Removed gloves. Wash hands.Record review of the facility's policy titled, Hand Hygiene, dated June 2020, reflected The facility considers hand hygiene the primary means to prevent the spread of infections .Facility Staff .must perform hand hygiene procedures in the following circumstances .Wash hands with soap and water .when soiled with visible dirt or debris .Hand hygiene is always the final step after removing and disposing of personal protective equipment