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	04/14/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 residents had a right to a dignified existence and self-determination that promoted enhancement of his or her quality of life, recognizing each resident's individuality for 4 (Residents #14, #21, #178 and #184) of 6 residents reviewed for resident rights. The facility failed to ensure Resident #178's Care Plan was followed. Resident #178's mattress was placed directly on the floor which could be seen by anyone who entered the men's behavioral unit due to the location of Resident #178's room.The facility failed to ensure residents' information was not loudly discussed in the dining room and/or down the hallway for anyone to hear as evidenced by the following: -CNA Q loudly stating it was embarrassing that Resident #21 urinated in his pants in the dining room.-CNA K loudly reporting Resident #178 did not want to eat anymore.-CNA Q loudly telling coworkers she was going to change Resident #184.-ADON M loudly telling CNA K that Resident #14 had taken his pants off and then CNA K told another CNA in the dining room. The failures could place residents at risk of a loss dignity.Findings included: An observation and interview on 04/12/2026 at 12:22 PM revealed Resident #178 laying on his mattress which was on the floor in his room. Resident #178 had taken off his hospital gown and wearing was wearing only an incontinent brief. Resident #178's room was the first room on the left going down the hall, the door was open and Resident #178's mattress on the floor could been seen while walking down the hall. RN L stated Resident #178's mattress had been moved to the floor because he fell overnight. RN L stated Resident #178 thinks he can still walk which was why he fell. Observation on 04/12/2026 at 1:00 PM revealed Resident #21 stated loudly that he needed to go to pee. CNA Q asked Resident #21 to hang on just a second. Staff were in the process of passing out lunch trays. CNA Q stated let's go ahead and go and Resident #21 stated, I've already gone. CNA Q walked up to Resident #21 and stated, That's embarrassing. Resident #21 stated It is embarrassing. Resident #21's pants and shirt were soiled and wet. CNA Q took Resident #21 out of the dining room and went to get him changed. Observation on 04/12/2026 at 1:16 PM revealed CNA K loudly tell RN L who was across the dining room [Resident #178] doesn't want to eat anymore held up a cup with protein shake in it and then walked to the trash can and threw it away. During an interview with ADON M on 04/13/2026 at 1:14 PM revealedPM she said she learned about Resident #178's mattress being moved to the floor when she came in to work on 04/12/2026. RN L reported the mattress was moved to the floor because Resident #178 fell. ADON M stated RN L made the decision on her own. RN L did not receive a physician's order or direction of the ADON or DON to move the mattress to the floor. ADON M stated such an action would be noted on the care plan. ADON M stated having the mattress on the floor was a dignity concern and a safety concern. Observation on 04/13/2026 at 1:31 PM revealed CNA Q loudly speak across the dining room which was full of residents, I'm going to change [Resident #184]. During an interview with DON on 04/14/2026 at 10:31 AM , she said she learned about Resident #178's mattress being placed on the floor as she was making rounds on 04/12/2026. DON stated this was a decision made by the nurse on the floor. DON stated she did not approve and there was no physician order in place. DON stated the bed should have been lowered and mats or mattresses (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	placed on the sides of the bed if there were concerns of the resident falling out of bed. DON stated this would result in a concern for Resident #178's dignity and safety by placing him on the floor. DON stated that if a resident needed assistance from a staff member she would expect the staff members to communicate with one another when they stepped away but should do it in a manner in which was dignified, not embarrassing or could mentally affect a resident by discussing their needs in front of everyone. DON stated this could be achieved by walking up to the person and speaking to their coworker or by whispering to one another. DON stated this behavior was monitored by making frequent rounds to observe staff and resident interactions. During an interview with CNA Q on 04/14/2026 at 11:18 AM she said if she needed to discuss a resident she would walk up to her coworker and not speak across the dining room. CNA Q stated this could be a HIPAA (Health Insurance Portability and Accountability Act) issue and should be confidential. Observation on 04/14/2026 at 11:26 AM revealed ADON M was walking down the hallway, about halfway down the hall , she turned around and loudly spoke with CNA K to tell another CNA [Resident #14] has taken his pants off and is walking down the hall. CNA K turned around and repeated the information to another CNA who was involved in an activity with a group of residents. During an interview with CNA K on 04/14/2026 at 11: 27 AM , she said if she and a coworker see saw someone is was soiled, she would walk up to her coworker to discuss the need and that she would be stepping away with the resident. CNA K stated it would be a concern of a dignity issue to discuss a resident where everyone could hear. CNA K stated a dignity concern could embarrass a resident or cause them to have behaviors. During an interview with Administrator on 04/14/2026 at 11:55 AM it was revealed that moving a mattress directly to the floor would be noted on the care plan. Administrator stated it was the preference of the facility to never have a mattress on the floor directly, it was preferred that a bed be put in the lowest position and mats beside the bed. Administrator explained the facility wanted residents to remain in a prideful situation and to never be ashamed or embarrassed and wanted them to be presented in a dignified manner. Administrator stated he expected staff to communicate resident needs with each other in a manner that did not broadcast information to everyone. Administrator explained this would be a concern a dignity issue. 1) Resident #178Review of Resident #178's admission Record dated 04/14/2026 revealed Resident #178 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #178 was diagnosed with Paranoid Schizophrenia (chronic mental health disorder characterized by intense, irrational delusions and auditory hallucinations), Senile Degeneration of Brain (progressive mental decline and brain atrophy associated with advanced age, characterized by memory loss, confusion, and reduced cognitive function), Schizoaffective Disorder (chronic mental health condition combining schizophrenia symptoms [hallucinations, delusions, disorganized speech] with major mood episodes [depression or mania]), and Dementia (memory loss). Review of Resident #178's MDS dated [DATE] revealed Resident #178's BIMS Summary Score was noted to be 09 meaning Resident #178 had moderate cognitive impairment suggesting noticeable memory issues or confusion. Resident #178 is was noted to have current active diagnosis diagnoses of Non-Alzheimer's Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-[NAME] diseases).Schizophrenia (e.g., schizoaffective and schizophreniform disorders). Review of Resident #178's Care Plan dated 02/01/2024 revealed Focus-[Resident #178] has impaired cognitive function/dementia or impaired thought processes r/t BIMS.Goal-[Resident #178] will maintain current level of cognitive function through the review date.[Resident #178] will be able to communicate basic needs on a daily basis through the review date.Interventions/Tasks.-Keep [Resident #178] routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. -Monitor/document /report [sic] to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status.Focus-[Resident #178]is at high risk for (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	falls.NOTE: There was no information regarding placing a mattress directly on the floor as an intervention for Resident #178's fall prevention. 2) Resident #21 Review of Resident #21's admission Record dated 04/14/2026 revealed Resident #21 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #21 was diagnosed with Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Dominant Side (damage to the right cerebral hemisphere and causes, in this specific case, the left-dominant-side [left-handed person] to be paralyzed or weak, often accompanied by spasticity, imbalance, and difficulties with everyday tasks). Review of Resident #21's MDS dated [DATE] revealed Resident #21's BIMS Summary Score was noted to be a 03 meaning Resident 03 had severe cognitive impairment suggesting Resident #21 had significant challenges with memory and orientation. Resident #21's primary medical condition was noted to be Other Neurological Conditions and Additional Active Diagnoses noted to be Cerebral Infarction (type of ischemic stroke caused by a blockage in brain blood vessels, leading to oxygen deprivation and localized tissue death.) 3) Resident #184 Review of Resident #184's admission Record dated 04/14/2026 revealed Resident #184 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #184 was diagnosed with Other Frontotemporal Neurocognitive Disorder (group of progressive brain diseases affecting the frontal and temporal lobes, causing severe changes in personality, behavior, language, and movement) and Dementia (memory loss). Review of Resident #184's MDS dated [DATE] revealed Resident #184's BIMS Summary Score was noted to be a 03 meaning Resident 00 had severe cognitive impairment suggesting Resident #21 184 had significant challenges with memory and orientation. Resident #184's Signs and Symptoms of Delirium was noted inattention and disorganized thinking continuously present. Resident #184 is was noted to have current active diagnosis of Non-Alzheimer's Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-[NAME] diseases).Schizophrenia (e.g., schizoaffective and schizophreniform disorders).Other Frontotemporal Neurocognitive Disorder (progressive personality, behavior, and language decline). 4) Resident #14 Review of Resident #14's admission Record dated 04/14/2026 revealed Resident #14 was an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted most recently on 05/21/2025. Resident #14 was diagnosed with Disorder of Brain (conditions affecting the brain, spinal cord, and nerves, causing symptoms like cognitive decline, memory loss, motor dysfunction, and sensory issues), Dementia (memory loss), and Bipolar (chronic mental health condition characterized by extreme mood swings, ranging from high-energy mania to intense depression). Review of Resident #14's MDS dated [DATE] revealed Resident #14's BIMS Summary Score was noted to be a 03 meaning Resident 03 #14 had severe cognitive impairment suggesting Resident #14 had significant challenges with memory and orientation. Resident #14's primary medical condition was noted to be Other Neurological Conditions and current active diagnosis diagnoses of Non-Alzheimer's Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-[NAME] diseases).Schizophrenia (e.g., schizoaffective and schizophreniform disorders).Bipolar Disorder .Psychotic Disorder. Review of Resident Rights policy dated 08/2020 revealed Purpose To to promote and protect the rights of all residents at the Facility. Policy All residents have a right to a dignified existence, self-determination, and communication with and access to person and services inside and outside the facility including those specified in this policy. The Facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The Facility will protect and promote the rights of the resident and provide equal access to quality of care regardless of diagnosis, severity of condition, or payment source. The Facility will ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the Facility. Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of residents' (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rights.Procedure I. State and federal law guarantee certain basic rights to all residents of the Facility. These rights include, but are no limited to, a resident's right to:.E. Privacy and confidentiality including the right to privacy in his/her specific oral, written, and electronic communications;.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, record review and interviews, the facility failed to ensure the resident had a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely for 4 of 18 resident beds (Resident bed #1, Resident bed #2, Resident bed #3, Resident bed #4) reviewed for bed linens. 1. The facility failed to ensure residents had linen that was clean and in good repair on Resident bed #1, Resident bed #2, Resident bed #3, and Resident bed #4 on 4/12/26 and 4/13/26.3. The facility failed to maintain enough linen on the downstairs secured unit. These failures could place residents at risk of exposure to infectious diseases, unsanitary environment and a decline in quality of life. Findings include: An observation of the downstairs secured unit on 04/12/2026 at 1:00 PM revealed Resident bed #1 and Resident bed #2 had soiled and worn linen, Resident bed #3 had soiled linen, and Resident bed #4 had soiled linen. In an interview on 04/13/2026 at 2:11 PM with LVN F, stated she was the charge nurse and has worked at the facility for several years. LVN F reported her expectation is that linens are changed if soiled. She reported CNAs are responsible for changing linens if soiled. She reported fresh linens are put on when residents have a bath, which is every other day. She reported that she must go to laundry about once per week because they do not have enough linen on the unit. She stated that she has reported the lack of linen to the ADON several times. An observation of the clean linen closet on the downstairs secured unit on 04/13/2026 at 2:14 PM revealed one face towel, approximately 10 body towels, approximately 15 blankets and sheets. Some towels were observed to have a light brown discoloration, most of the linen observed was in poor condition and looked soiled or worn. LVN F reported that the next shift (3-11PM) will need to have linen for showers and there were not currently enough on the unit. An observation of Resident bed #1, Resident bed #2, Resident bed #3, and Resident bed #4 on 04/13/2026 at 2:27 PM revealed Resident bed #4's linen was soiled, stained, and worn as described by LVN F. She stated the bed needed to be changed. LVN F described Resident bed #3 as having soiled, stained, and worn linens. She stated the bed needed to be changed. Resident bed #1 did not have a pillowcase covering the pillow, the pillow appeared cracked all over the surface. Resident bed #1 did not have a blanket. The sheet observed on Resident bed #1 was described as stained and soiled by LVN F. LVN F stated she recommended the pillow be thrown away and linen changed on Resident bed #1. Resident bed #2 did not have a pillowcase covering the pillow. The pillow on Resident bed #2 was cracked and torn with filling hanging out of the bottom. The blanket on Resident bed #2 was described by LVN F as worn and stained. LVN F stated she also recommended the pillow be thrown away and linen changed on Resident bed #2. LVN F reported that soiled and worn linen impacts the residents' dignity. She stated she likes nice things and she thinks the residents would also. In an interview on 04/13/2026 at 2:33 PM with CNA G she reported that she has changed her resident's bedding daily because they are dirty and it makes the rooms feel clean. She reported that staff do not always have enough towels to dry residents after baths so they will sometimes use sheets to dry residents. She stated she has reported the shortage to whichever nurse is on duty. She reported that laundry staff have been shorthanded. She reported that she observed the sheets and towels on the unit to be dingy in color. She reported the sheets are too big for the beds making it hard to keep them tidy. She reported that linens look old and the texture of the towels are hard. She reported that the linen issued affect resident dignity as they are unable to do for themselves. In an interview on 4/14/2026 at 10:19 AM with CNA H she reported to have worked at the facility for 2 years. She reported beds are changed on resident's shower days which are every other day. She reported sometimes there is not enough linen, so she strips the bed and waits for the linen to come. She reported that if clean linen comes during her shift, she makes the bed, if not, she leaves it for the next shift. She reported that if a resident wants to lay down while clean linen is not available, she will go get linen from the laundry. She reported sometimes they do not have enough towels for residents (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to shower, and she must tell the nurse who will go to the laundry and get some. She reported the quality of the sheets and towels are ok, but they do need more. She reported that the unit could use some new pillows because there are some pillows that had cracks. She stated residents' quality of care is affected by the linen in poor condition and insufficient amount of linen. She reported that sleeping without good pillows could cause neck pain. In an interview on 04/14/2026 at 10:43 AM with the Housekeeping Manager he reported he has worked at the facility for two weeks and with the company for eight to nine years. He stated the facility was expected to maintain three times the amount of linen per resident. He reported he had not completed a linen inventory since starting. He reported his expectations are that linen inventories were conducted monthly, and replacements were to be ordered when supplies were insufficient. He reported that laundry staff evaluated soiled linens for stains after each wash. If there is a concern that linen is still stained or soiled, they are first rewashed using extended wash cycles and additional chemicals. After a second wash linens are inspected again to determine if they would continue to be used or set aside to be discarded. He reported that he or the Housekeeping Lead reviewed linen to determine which items should be discarded or replaced. He stated assessments and inventory were documented in a log. The log was not available for review when requested. He stated pillows were laundered with all linens and replaced when damaged. He stated that poor-quality or insufficient quantity of linens negatively impacted residents' dignity, comfort, and sense of a homelike environment. In an interview on 04/14/2026 at 11:26 AM with the Housekeeping Lead, she reported to have been at the facility about 6 to 7 years. She reported that she observed the condition of pillows linens on the downstairs secured unit yesterday. She reported that she stayed late on 4/13/2026 and replaced some linen on the unit. She reported that linen was being discarded but it was not being documented by staff, leading to a shortage of linen. She stated that she will resolve the problem by doing an in service with staff about how to properly assess which linen should be rewashed and which should be discarded. She stated the expectation is for the facility to have three times the amount of linen than residents. She reported that she inventoried last night on 04/13/2026 and will place an order today to have the correct pieces of linen. She reported that not having linen in good repair and not having enough linen for residents can result in unsanitary conditions and does not create a homelike environment. On 04/14/2026 at 11:39 AM in an interview with the facility administrator, he reported he has been the administrator at the facility for 2 and a half years. He stated his expectation regarding linen is for staff to replace any torn or tattered linen. He stated CNAs who observe worn linen should notify a nurse or housekeeping manager. He reported that the impact to residents of soiled and insufficient amount of linen is they can receive a delay in care and experience decreased happiness. Review of the facility laundry services policy dated August 2020 reflects A. The Facility employs adequate staff to ensure that linen is kept clean, in good repair, and in sufficient quantities to meet the needs of our patients. B. At all times, the Facility maintains enough linens consistent with state and federal regulations for every licensed bed. These failures could place residents at risk of exposure to infectious diseases, unsanitary environment and a decline in quality of life.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 4 of 12 residents (Resident#10, Resident#15, Resident#50,and Resident #169) reviewed for ADL care.The facility failed to provide Resident #169 assistance with timely incontinence care for at least 4 hours.The facility failed to ensure Resident #10 had his fingernails cleaned and trimmed on 04/12/26.The facility failed to ensure Resident #15 had his face cleaned and his eye free of buildup on 04/13/26.The facility failed to ensure Resident #50 had her fingernails cleaned and trimmed on 04/12/2026. These failures could place residents at risk for loss of dignity, risk for infections and a decreased quality of life. Findings included: 1.Record review of Resident #169's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] with medical diagnoses of Dementia (a decline in mental ability), Muscle Wasting and Atrophy (loss of muscle mass), Hypertension (high blood pressure), Abnormalities of Gait and Mobility (irregularities in walking or running), Anemia (a lack of healthy red blood cells), and Disseminated Intravascular Coagulation (a blood clotting disorder). Record review of Resident #169's quarterly MDS assessment, dated 04/03/2026, reflected a BIMS score of 13, which indicated intact cognitive response. Section GG0103-Functional Abilities revealed Resident #169 was dependent on staff for toileting.Review of Resident #169's care plan, dated 01/02/2026, revealed Resident #169 had an ADL Self Care Performance Deficit related to impaired mobility. Goal: Improve current level of function in Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene. Intervention: Resident requires dependent staff participation with toileting hygiene. Resident #169 has bowel and bladder incontinence related to impaired mobility. Goal: Resident will remain free from skin breakdown due to incontinence and brief use. Monitor/document for symptoms of UTI. Monitor/document/report to MD PRN possible medical causes of incontinence. During an observation and interview on 04/12/26 at 11:53 a.m., Resident #169 was observed with a soiled brief. Resident #169 stated he was not changed today and changing was not offered by staff. During an interview on 04/12/26 at 11:59 a.m., CNA C revealed he rounded every 2 hours and provided incontinence care during rounds and when needed. CNA C stated Resident #169 was changed prior to breakfast which was around 8am. CNA C stated delayed incontinence care could put residents at risk for bedsores. During an interview on 04/12/26 at 1:21 p.m., CNA E stated incontinence care was provided every 2 hours during rounds. She stated delayed incontinence care was considered neglect and caused skin breakdown and depression. During an interview on 04/12/26 at 1:55 p.m., CNA D stated incontinence care was provided during rounds every 2 hours and as needed. He stated residents were at risk for bed sores if incontinence care was delayed. During an interview on 04/14/26 at 1:06 p.m., the DON stated CNAs were responsible for checking on residents and providing incontinent care every 2-3 hours and as needed. She stated nurses were also responsible for checking on residents to ensure their needs were met. The DON stated delayed incontinence care placed Resident #169 at risk of infection, skin breakdown, and dignity issues. 2. Record review of Resident #10's quarterly MDS assessment, dated 02/01/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #10 had diagnoses which included hypertension (high blood pressure), non-Alzheimer's dementia (diseases that affect memory, thinking, and the ability to perform daily activities), and Hemiplegia or Hemiparesis (Hemiparesis refers to mild-to-moderate weakness, allowing some muscle movement. Hemiplegia is more severe, resulting in total paralysis or complete loss of movement control on one side). Resident #10 had a BIMS score of 07/15 which indicated Resident #10's cognition was severely impaired. Resident#10 required Substantial/maximal assistance with personal hygiene. Record review of Resident #10's Comprehensive Care Plan dated 02/23/26 reflected the following: Focus: [Resident #10] has an ADL Self Care Performance Deficit r/t hemiplegia. Goal: [Resident #10] will improve (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	current level of function in (Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene, ADL Score) through the review date. Personal hygiene: [Resident#10] requires sub/max with personal hygiene . During an observation and interview on 04/12/26 at 12:19 PM, Resident #10 was observed lying in bed watching TV. Resident #10's nails on both hands were approximately 0.4 cm in length extending from the tip of his fingers, and dirty. Resident #10 stated, he would like to have his fingernails cleaned and trimmed. Observation and interview on 04/12/26 at 1:29 PM revealed CNA O looked at Resident #10's fingernails and stated they looked long, dirty and needed to be cleaned, and trimmed. CNA O stated CNAs were responsible to clean and trim residents' nails during the showers. CNA O stated only nurses cut residents' nails if they were diabetic. CNA O stated the risk would be potential for infection and skin integrity problems. In interview on 04/13/26 at 10:29 AM revealed LVN P stated CNAs were responsible for cleaning and trimming residents' nails during the showers. LVN P stated only nurses cut residents' nails if they were diabetic. LVN P stated it was the responsibility of the charge nurses for the Hall to make sure residents were getting appropriate care. LVN P stated the risk to residents was development of infection and skin integrity problem. 3. Record review of Resident #15's quarterly MDS assessment, dated 02/19/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #15 had diagnoses which included Cerebrovascular Accident (a medical emergency occurring when blood flow to the brain is interrupted (ischemic) or a vessel bursts (hemorrhagic), causing rapid brain cell death), non-Alzheimer's dementia (diseases that affect memory, thinking, and the ability to perform daily activities), extrapyramidal and movement disorder (drug-induced or neurological movement disorders affecting involuntary motor control, often caused by dopamine-blocking medications like antipsychotics.), and Bipolar Disorder (a chronic mental health condition characterized by severe mood swings, ranging from extreme highs (mania/hypomania) to intense lows (depression)). Resident #15 had a BIMS score of 12/15 which indicated Resident #15's cognition was moderately impaired. Resident#15 was dependent with personal hygiene. Record review of Resident #15's Comprehensive Care Plan dated 02/12/26 reflected the following: Focus: [Resident #15] has an ADL Self Care Performance Deficit r/t extrapyramidal and movement disorder. Goal: [Resident #15] will maintain current level of function in ADL's through the review date. Personal hygiene: [Resident#15] is dependent with personal hygiene . During an observation and interview on 04/13/26 at 09:30 AM, Resident #15 was observed lying in bed. Resident #15's face looked oily and there was a buildup from his eyes that looked white, pale cream, accumulating in the inner corner by the nose. Resident#15 stated his face was not cleaned today, and they only cleaned his face during the shower times. Observation and interview on 04/13/26 at 09:35 AM revealed CNA P looked at Resident #15's face and stated there was a buildup from his eyes. CNA N stated CNAs were responsible to clean Resident's face daily, and she did clean Resident#15's face this morning around his nose and mouth, but not his eyes. CNA N stated the risk to the Resident would be potential development of infection and loss of dignity. In interview on 04/13/26 at 1:36 PM revealed LVN P stated CNAs were responsible to keep residents cleaned and groomed all the time. LVN P stated it was the responsibility of the charge nurses for the Hall to make rounds, check residents to make sure residents were getting appropriate care. LVN P stated the risk to residents was development of infection, skin integrity problem, dignity issue. 4. Record Review of Resident #50's Quarterly MDS assessment dated [DATE] as a [AGE] year-old male with readmission date of 11/14/2025 to the facility. His pertinent diagnoses included multiple sclerosis (a chronic autoimmune disorder causing immune disease where the immune system attacks the myelin sheath protecting nerves in the brain and spinal cord, causing communication issues between the brain and body), and dementia (cognitive decline including memory loss). His BIMS score was 11, which indicated Resident #50's cognition was moderately impaired. Resident #50 was dependent on staff for his personal hygiene. Review of Resident #50 's Comprehensive Care Plan, revised 12/02/2025 reflected, Focus: [Resident #50] has an ADL self-care performance deficit.Interventions: Bathing: [Resident #50] . Nail care weekly and as needed . In an observation on 05/12/2026 at 11:49 AM (continued on next page)

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	04/14/2026

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed resident #50 had long nails on both hands, they were approximately 0.4cm in length extending from the tip of his fingers. The nails were discolored tan and the underside and the nail beds had dark brown colored residue. Resident #50 was confused unable to answer questions. In an interview on 04/12/2026 at 12:26 PM with CNA A stated that Nurses and CNAs were responsible for cleaning and trimming residents' fingernails. She stated that for residents with diabetes, Nurses were responsible for trimming fingernails as needed. CNA A stated the risks of long, dirty fingernails included increased risk of infection and decreased quality of life. During an interview on 04/14/26 at 11:33 AM, the DON stated CNAs were responsible for checking on residents and providing appropriate care and grooming every shift and as needed. She stated the nurses in charge for the Halls were also responsible for checking on residents to ensure their needs were met. The DON stated not providing appropriate care, and grooming placed residents at risk of infection, skin breakdown, and dignity issues. Review of the facility's Care and Services policy, revised 06/2020, reflected: Residents are provided with the necessary care and services to maintain the highest practicable physical, mental, and social well-being level of in an environment that enhances quality of life in the scope of long-term care facility. Care and services are provided in a manner that consistently enhances self-esteem and self-worth. Review of the facility's undated policy, titled Grooming Care of the Fingernails and Toenails reflected: Nail care is given to clean and keep the nails trimmed. I. Fingernails are trimmed by Certified Nursing Assistants except for residents with the following conditions: A. Diabetes or circulatory impairment of the hands. B. Ingrown, infected, or painful nails. C. Nails that are too hard, thick, or difficult to cut easily.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that each resident received, and the facility provided at least three meals daily, at regular times comparable to normal mealtimes in the community for two (lunch on 04/12/26 and 04/13/26) of two meals observed for dietary services. The facility failed to serve the 04/12/26 and 04/13/26 lunch meals on time at the scheduled time based on the meal postings. This failure could place residents at risk for decreased meal satisfaction, decreased intake, loss of appetite, side effects from medications given without food, and diminished quality of life. Findings included: Review of Resident #174's admission MDS assessment dated [DATE] reflected Resident #174 had a BIMS of 14 indicating he was cognitively intact. Review of Resident #37's Quarterly MDS assessment dated [DATE] reflected Resident #37 had a BIMS of 14 indicating he was cognitively intact. Review of Resident #38's quarterly MDS assessment dated [DATE] reflected Resident #38 had a BIMS of 8 indicating he was moderately cognitively impaired. Interview on 04/12/26 at 12:45 PM with Resident #174 revealed lunch trays were late and 200 hall was served last. Observation revealed 200 hall had not received their lunch trays yet. Observation on 04/12/26 at 1:36 PM revealed the last lunch hall tray was passed to residents on 200 hall. Interview on 04/12/26 at 1:38 PM with Residents #37 and #38 revealed breakfast and lunch trays were late most times and their hall was last served each day. They both preferred to eat in their room. Observation on 04/12/26 at 2:01 PM in the main dining room of meal times posting revealed lunch 12:00 PM. In a confidential group interview at an undisclosed date and time with 6 residents revealed resident meal trays were served late at times. Observation on 04/13/26 at 12:54 PM revealed the last hall tray was passed to residents on 200 hall. Interview on 04/13/2026 at 2:52 PM with CNA E revealed 200 hall lunch trays were last. She stated it varied when they received lunch trays from the kitchen and stated it could take from 12:30 PM to 1 PM at times before residents are given their meal trays. She stated the risk to residents receiving their meal trays late could be angry residents and cold food. Interview on 04/14/2026 at 12:02 PM with LVN T revealed lunch meal times were posted at noon but hall trays can take up to 1:30 PM at times to be served to residents. She stated 200 hall lunch trays were last to be served to the halls. She stated hall trays being late can place residents at risk of hunger and delay in getting their food. Interview on 04/14/2026 at 1:16 PM with Dietary Manager revealed meal times are posted for lunch at 12 pm and did not designate between dining and hall trays. She stated dining room trays for lunch start at noon and hall trays can take at times from 12:45 PM to 1:30 PM before all residents receive their lunch including hall trays. She stated the facility could be clearer in designating time frames of when hall trays were passed. She stated hall 200 was usually the last hall for meals to be served but she stated going forward the facility could take turns with different halls going last so 200 hall did not go last each day. She stated the risk to residents getting meal trays late could put the food at risk to be cold. Dietary Manager was unaware of any complaints of hall trays being late. Review of facility's policy Meal Service Times last revised 01/01/2026 reflected Meals are served at regularly scheduled hours.The Dietary Manager is responsible for monitoring meal service time daily to ensure the facility meets posted mealtimes.

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	455653	A. Building B. Wing	04/14/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 5 residents (Resident #164, # 21, 157, 184, and #105) of 10 residents observed for infection control. The facility failed to ensure:CNA B changed gloves and completed hand hygiene during incontinent care for Resident #164 on 4/12/26.CNA K did not utilize her bare hands when assisting Residents #21, #157 and #184 during lunch on 04/12/2026.CNA N wore appropriate PPE and completed hand hygiene during incontinent care for Resident #105, who was on Enhanced Barrier Precaution, on 4/13/26. These failures could place residents at risk for infection and cross contamination of pathogens and illness. Resident #164 Record review of Resident #164's Quarterly MDS assessment dated [DATE] reflected Resident #164 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia (decline in mental ability such as memory, reasoning, and thinking, severe enough to interfere with daily life), muscle weakness, and cognitive communication deficit. Resident #164's BIMS score of 7 indicated Resident #164's cognition was severely impaired. The MDS assessment indicated Resident #164 required maximal assistance (the helper assists with more than 50% of the activity) with toileting hygiene. Observation on 04/12/26 at 12:00 PM revealed CNA B entered Resident #164's room to provide incontinence care. She washed her hands and donned gloves. CNA B unfastened Resident #164's brief, she then provided peri-care to the resident, wiping across the resident's pubis bone and then down each groin. CNA B dropped the clean brief on the floor; she picked it up and put it back on the resident bed. CNA B rolled resident on her side, she wiped the resident's buttock area with peri-wipes, front to back. She then removed the soiled brief and with soiled gloves, placed the brief that she picked up from the floor, under the resident. With the same gloves on she applied skin barrier cream to the resident's buttocks. She removed and discarded the dirty gloves; she donned the clean gloves without any kind of hand hygiene. She rolled the resident on her back onto the clean brief. Once finished, she fastened the resident's brief, she covered resident and she lowered the resident's bed to low position. She removed and discarded gloves and washed her hands. In an interview on 04/12/26 at 12:13 PM, CNA B stated she should change her gloves and perform hand hygiene when she went from dirty to clean. CNA B stated she should not pick up the brief from the floor and put it back on the resident bed. She stated failing to provide proper care would expose the residents to infections. In an interview on 04/14/26 at 10:45 AM, the DON stated she expected the staff to remove their gloves and sanitize their hands when going from dirty to clean. If a CNA dropped the brief on the floor her expectation was for the CNA to discard the brief and get a clean brief. The DON stated CNAs were trained to perform hand hygiene between change of gloves. She stated failure to do so would potentially lead to cross-contamination and possible spread of infection. She stated she would educate all nursing staff and the ADONs would do random rounds for monitoring. 2. Resident #21 (continued on next page)

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	04/14/2026

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #21's face sheet dated 04/14/2026 revealed Resident #21 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #21 was diagnosed with Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Dominant Side (damage to the right cerebral hemisphere and causes, in this specific case, the left-dominant-side [left-handed person] to be paralyzed or weak, often accompanied by spasticity, imbalance, and difficulties with everyday tasks). Review of Resident #21's Care Plan dated 03/16/2026 revealed Focus-[Resident #21] has an ADL Self Care Performance Deficit.Goal-[Resident #21] will maintain current level of function in ADL Score through the review date.Interventions/Tasks-EATING: The resident required (1) staff participation to eat. Resident #157 Review of Resident #157's face sheet dated 04/14/2026 revealed Resident #157 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #157 was diagnosed with Dysphagia (difficulty swallowing), Dementia (memory loss), and Delirium (acute, fluctuating state of confusion, inattention, and altered consciousness, often stemming from underlying medical conditions, infections, or medication side effects). Review of Resident #157's face sheet dated 02/17/2026 revealed Focus-The resident has nutritional problem or potential nutritional problem.DEMENTIA AND DELIRIUM.Goal-The resident will comply with recommended diet for STABILITY IN weight through review date.Interventions/Tasks-GIVE FINGER FOODS WITH MEALS, HEALTH SHAKE/ICE CREAM AS ORDERED.Monitor/document/report to MD PRN for s/sx of dysphagia; Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Resident #184 Review of Resident #184's face sheet dated 04/14/2026 revealed Resident #184 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #184 was diagnosed with Other Frontotemporal Neurocognitive Disorder (group of progressive brain diseases affecting the frontal and temporal lobes, causing severe changes in personality, behavior, language, and movement) and Dementia (memory loss). Review of Resident #184's Care Plan dated 12/31/2025 revealed Focus-The resident has an ADL Self Care Performance Deficit r/t Confusion, Dementia.Goal-The resident will maintain current level of function in [Specify Bed Mobility, Transfers, Eating, Dressing, Toilet Use, and Personal Hygiene; ADL Score) through the review date.Eating: The resident requires (supervision from) staff participation to eat. During an interview with RN L on 04/12/2026 at 12:22 PM revealed Resident #21 required assistance of one staff for all ADLs, and Resident #184 required assistance with ADLs including assistance with eating. Observations on 04/12/2026 from 1:00 PM to -1:20 PM revealed Resident #184 had a whole pork chop on his plate. Resident #184 was struggling to eat the meat due to the size and not being able to cut up the meat. CNA K observed Resident #184 and went over to assist him. CNA K used her bare thumb and pointer finger to hold down the pork chop and used Resident #184's fork to cut up the meat into bite sized pieces. CNA K then went over to Resident #21 and assisted him by cutting up Resident #21's (continued on next page)

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	04/14/2026

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pork chop. CNA K held down the pork chop with her bare thumb and pointer finger. Then CNA K used the fork to cut up the meat into smaller bites. After CNA K was finished, she walked over to Resident #184 and assisted in feeding him. CNA K was holding her two fingers out to her side where gravy and meat particles could be seen. CNA K then went to the sink a few minutes later and washed her hands. At 1:20 PM CNA K went and picked up Resident #157's plate to get him to sit down to eat. CNA K picked up a chicken finger with her bare hands and walked across the dining room and handed Resident #157 the chicken finger. During an interview with Administrator on 04/14/2026 at 11:55 AM Revealed the staff should assist residents with cutting up their food when trays are passed out to the resident. The staff should utilize the residents' utensils to cut up meats. The staff should not use bare hands to touch the food. Staff should sanitize in between assisting residents. During an interview with DON on 04/14/2026 at 12:16 PM revealed staff were expected to utilize a knife and fork to cut up resident foods. DON stated the staff should use utensils or gloves when cutting up food and should never use bare hands due to concerns of infection control. DON stated infection control practices were monitored by her, the ADONs, and nurses by making rounds during meals. During an interview with CNA K on 04/14/2026 at 12:20 PM revealed when meals came to the unit knives were not provided to assist with cutting up food. CNA K stated she had to utilize a fork and spoon to cut meat. CNA K stated she did not realize she used her fingers until it was pointed out. CNA K stated she should not ever touch a resident's food because her hands could be dirty and could have spread germs. 3. Resident #105 Record review of Resident #105's annual MDS assessment, dated 02/17/26, reflected an [AGE] year-old male who was admitted to the facility on [DATE], and readmitted on [DATE]. Resident #105 had diagnoses which included hypertension (high blood pressure), type 2 diabetes mellitus (high blood sugar), Cerebrovascular Accident (a medical emergency occurring when blood flow to the brain is interrupted (ischemic) or a vessel bursts (hemorrhagic), causing rapid brain cell death) ,non-Alzheimer's dementia (diseases that affect memory, thinking, and the ability to perform daily activities), and Hemiplegia or Hemiparesis (Hemiparesis refers to mild-to-moderate weakness, allowing some muscle movement. Hemiplegia is more severe, resulting in total paralysis or complete loss of movement control on one side). Resident #105 had a BIMS score of 05/15 which indicated Resident #105's cognition was severely impaired. Resident#105 was always incontinent for bowel/bladder. Record review of Resident #105's Comprehensive Care Plan dated 02/23/26 reflected the following: Focus: [Resident #105] is on Enhanced Barrier Precautions R/T wound. Goal: Reduce transmission of pathogens. Interventions: Staff members will wear a clean gown and gloves while performing high contact resident care activities to include Dressing, Bathing/Showering, transferring, providing hygiene, changing linens, changing briefs or toileting assistance, and/or caring for indwelling medical devices like central lines. Staff to follow standard precautions. Observation on 04/13/26 at 09:10 AM revealed Resident #105 was on Enhanced barriers precautions. (continued on next page)

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	04/14/2026

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was signage on the room door that informed visitors/staff he was on enhanced barriers precautions, perform hand hygiene before and after leaving room, necessary PPE to wear in room, and donning/doffing (put on/remove) information. CNA N entered Resident #105's room without wearing any form of PPE, there was PPE organized hanging on the door of Resident#105 room. CNA N washed hands, donned gloves and procced to do incontinent care for Residnt#105 without wearing gowns. CNA N uncovered Resident#105, unfastened the Brief. CNA N cleaned Resident#105 front area using one wipe per stroke. CNA N helped Resident#105 turned to his right side, cleaned Resident#105 buttocks area using one wipe per stoke, and removed the dirty brief, the brief was soiled with feces. CNA N then placed the dirty brief in the trash can. CNA N changed gloves without performing any kind of hands hygiene (washing or sanitizing). CNA N applied the clean brief, fastened the brief, and assisted the resident to position in bed. After care, CNA N completed hand hygiene and exited the room. Interview with CNA N on 04/13/26 at 09:32 AM revealed that she was supposed to wear gown for the resident peri care, but she forgot. She stated she was nervous. She stated she was in-serviced regarding different types of infection control. She stated the risk of not wearing proper PPE in enhanced barriers precautions residents' rooms was exposing herself and others to the development of infection and spreading germs from one resident to another resident. CNA N stated she was supposed to complete hand hygiene before and after care. CNA N stated she was supposed to clean her hands every time she changed gloves. CNA N stated she was supposed to complete hand hygiene to prevent the spread of infection. In interview on 04/14/26 at 11:33 AM, The DON stated for the EBP they had signage outside the resident's room, and for any high contact activity with the resident on EBP including transfer, peri care, staff should be gowning and gloving (putting on gown, and gloves). The DON stated her expectation was for the direct residents' care staff member to perform hands hygiene any time they changed their gloves. She stated she and the ADONs were responsible for training staff on infection control. The DON further stated training for EBP was done on hire, on monthly staff meeting, and as needed. The DON stated they used EBP to prevent infection to high-risk residents. Review of Hand Hygiene policy dated 06/2020 revealed Purpose.To ensure that all individuals use appropriate hand hygiene while at the Facility. Policy.The Facility considers hand hygiene the primary means to prevent the spread of infections. Procedure.I. Facility Staff are trained and regularly in-services on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. II. Hand hygiene observations may be observed and recorded by the Infection Control Designee on a monthly basis and results reported to QA. III. Facility Staff follow the hand hygiene procedures to help prevent the spread of infections to other staff, residents, and visitors. IV. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policy. V. Facility staff and volunteers must perform hand hygiene procedures in the following circumstances including but not limited too .A. Wash hands with soap and water:.iii. When soiled with visible dirt or debris; iv. After unprotected (ungloved and damaged gloves contact with blood, other body fluids, secretions, excretions, mucous membranes, non-intake skin, intact skin soiled with blood and other body fluids, wound drainage and soiled dressings; vi. Before and after food preparation.

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	455653	A. Building B. Wing	04/14/2026

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the responsible party regarding changes in condition for 1 (Resident #178) of 6 sampled residents reviewed for changes in condition and resident rights. The facility failed to notify Resident #178's responsible party when he had a fall and when he had a newly acquired pressure wound. This failure could place residents at risk of not having their responsible party notified of changes resulting in a delay in medical intervention.Review of Resident #178's admission Record dated 04/14/2026 revealed Resident #178 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #178 was diagnosed with Paranoid Schizophrenia (chronic mental health disorder characterized by intense, irrational delusions and auditory hallucinations), Senile Degeneration of Brain (progressive mental decline and brain atrophy associated with advanced age, characterized by memory loss, confusion, and reduced cognitive function), Schizoaffective Disorder (chronic mental health condition combining schizophrenia symptoms [hallucinations, delusions, disorganized speech] with major mood episodes [depression or mania]), and Dementia (memory loss). Contacts:.Name-[Federal Fiduciary] Contact Type-Responsible Party, Emergency Contact #2 Relationship-Other.Name-[Family Member], Contact Type-Responsible Party, Care Conference Person, Emergency Contact #1.NOTE: Federal Fiduciary was listed over the Family Member even though the Family Member was noted as the #1 Emergency Contact. Review of Resident #178's MDS dated [DATE] revealed Resident #178's BIMS Summary Score was noted to be 09 meaning Resident #178 had moderate cognitive impairment suggesting noticeable memory issues or confusion. Resident #178 is noted to have current active diagnoses of Non-Alzheimer's Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-[NAME] diseases).Schizophrenia (e.g., schizoaffective and schizophreniform disorders). Review of Resident #178's Care Plan dated 02/01/2024 revealed Focus-[Resident #178] has impaired cognitive function/dementia or impaired thought processes r/t BIMS.Goal-[Resident #178] will maintain current level of cognitive function through the review date.[Resident #178] will be able to communicate basic needs on a daily basis through the review date.Interventions/Tasks.-Keep [Resident #178] routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. -Monitor/document /report [sic] to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status.Focus-[Resident #178]is at high risk for falls. Review of Resident #178's Fall with Injury report dated 04/12/2026 at 03:45 (3:45 AM) revealed Incident Description.Nursing Description: On rounding staff called this nurse and mentioned that resident was on the floor. This nurse went and found the resident lying on the floor with blood above his right eye. Head to toe assessment and vitals were done, a skin tear observed above his right eye.mentioned no pain: the staff was told by the resident that he fell off his bed when he was trying to turn over. Eye cleaned with normal saline and left to dry in open air. Resident put in his bed, with bed at the lowest position and call light placed within reach, NP.DON, RP [Federal Fiduciary] and Hospice notified.Agencies/People Notified.Physician [with Physician's Name].Family Member [Federal Fiduciary].DON/RN [DON] Review of Resident #178's Progress Note dated 04/12/2026 revealed Effective Date: 04/12/2026 04:37 [4:37 AM].On rounding staff called this nurse and mentioned that resident was on the floor. This nurse went and found the resident lying on the floor with blood above his right eye. Head to toe assessment and vitals were done, a skin tear observed above his right eye.mentioned no pain: the staff was told by the resident that he fell off his bed when he was trying to turn over. Eye cleaned with normal saline and left to dry in open air. Resident put inhis [sic] bed, with bed at the lowest position and call light placed within reach, (continued on next page)

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	455653	A. Building B. Wing	04/14/2026

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NP.DON, RP [Federal Fiduciary] and Hospice notified. Review of Resident #178's Progress Note date 03/23/2026 revealed Effective Date: 03/23/2026 at 14:42 PM [2:42 PM].Resident was seen by wound md left lateral foot diabetic ulcer area is improving and continue with current treatment, [Federal Fiduciary] was visiting and informed her of status of wound and notified hospice will continue to monitor. Review of Resident #178's Progress Note dated 03/30/2026 revealed Effective Date: 03/30/2026 at 16:00 [4:00 PM].Resident was seen by wound md for diabetic ulcer to left lateral foot area is improving and continue with current treatment order and called rp [Federal Fiduciary] and informed of wound status and hospice also will continue to monitor. Review of Resident #178's Progress Note dated 04/06/2026 revealed Effective Date: 04/06/2026 10:49 AM revealed .WOUND ASSESSMENT: Wound: 1 Location: Left Lateral Foot Primary Etiology: Diabetic/Neuropathic ulcer.Status: Subsequent-Improving.Wound: 2 Location: Sacrum Primary Etiology: Kennedy terminal ulcer.Status: new. During an interview with Family Member on 04/12/2026 at 3:12 PM it was revealed that Family Member was aware Resident #178 had had falls at the facility. As a result, Resident #178 was moved closer to the nurse's station. Family Member denied being called on 04/12/2026 when Resident #178 had a fall. Family Member denied knowing Resident #178 had any additional wounds other than on his foot, which he had for an extended period of time. Attempt to contact Federal Fiduciary on 04/14/2026 at 9:57 AM. A message was left for a return call. During an interview with Family Member on 04/14/2026 at 9:58 AM revealed Federal Fiduciary was not related to Resident #178. Federal Fiduciary was appointed by the Veterans Affairs (VA) to ensure Resident #178's VA benefits were paid to the facility. Family Member stated she was Resident #178's Medical Power of Attorney. Family Member stated she had never met Federal Fiduciary. Family Member stated she was not contacted by Federal Fiduciary and if the facility mistakenly contacted her by accident of Resident #178 change in medical condition. Family Member stated as POA she should be the only person notified of any changes in medical condition. During an interview with BOM on 04/14/2026 at 10:03 AM revealed Family Member of Resident #178 was the Financial and Medical POA which was verified by looking in Resident #178's EHR. BOM explained when Resident #178 was admitted to the facility his VA benefits were being held. It was determined Resident #178 had a representative from VA appointed to him which was Federal Fiduciary. BOM explained Federal Fiduciary came monthly to pay Resident #178's applied income, ensure Resident #178 had money available in his trust fund for items he may need and annually would provide bank statements so that Resident #178's Medicaid renewaled. Otherwise, Federal Fiduciary was not involved with Resident #178's medical care. BOM stated Family Member was very involved and visited frequently. During an interview with Federal Fiduciary on 04/14/2026 at 10:17 AM it was revealed she worked for the VA. Federal Fiduciary explained that the Department of Veterans Affairs demeaned Resident #178 incompetent to manage his own finances and she was put in place to manage his VA benefits. Federal Fiduciary stated she paid his applied income and ensured he had money in his trust fund. Federal Fiduciary stated she managed his finances but did not have anything to do with Resident #178's medical care. Federal Fiduciary stated she was not Resident #178's Guardian. Federal Fiduciary stated she had been called by the facility in the past and stated she had explained she was not the person to be contacted. Federal Fiduciary stated she was not contacted on 04/12/2026 regarding Resident #178 having a fall and had not recently been contacted regarding Resident #178's wound care. During an interview with ADON M on 04/14/2026 at 10:21 AM it was revealed if there was a change of condition with a resident, including new wounds or wound changes, falls, the family should be notified. Resident #178 had Family Member to be contacted. ADON M stated Resident #178 had a fall on 04/12/2026. ADON M stated she would then follow-up the following day to ensure everyone was notified, review the incident report, she would conduct a follow-up secondary skin assessment and then would ensure there was documentation of 72 hours of documentation. ADON M stated she was not aware of who, if anyone, was contacted regarding Resident #178's most recent fall on 04/12/2026. During an interview with DON on 04/14/2026 at 10:31 AM it was revealed that if a resident had a change in condition (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including falls and wounds the nurse was to notify the DON, ADON, family and/or hospice. DON explained the nurses usually went ahead and notified the family as well. DON explained the ADON's did follow-up after incidents to ensure such notifications were made. During an interview with Treatment Nurse on 04/14/2026 at 11:11 AM she saidrevealed she started seeing Resident #178 due to a vascular wound on his foot. Resident #178 now had a new wound on his buttocks that the Wound Care Physician noted to be a [NAME] Ulcer (meaning it was non-avoidable and terminal). Treatment Nurse stated she thought she was notifying Family Member but was not for sure who she documented notifying. Treatment Nurse stated she was to notify responsible parties/families when there were changes to wounds or new wound developed. During an interview with Family Member on 04/14/2026 at 11:30 AM it was revealed she was just told by the Treatment Nurse that Resident #178 had a new wound on his buttocks. Family Member stated she was not aware of any additional wounds other than his foot until today. During an interview with Administrator on 04/14/2026 at 11:55 AM it was revealed when there was any change to a resident the nurse was expected to notify hospice, POA, and nursing leadership. Administrator explained with Resident #178 Family Member should be contacted. Administrator stated he was not sure who Federal Fiduciary was or why she was listed first on the Face Sheet. Review of Change of Condition Notification policy dated 01/2025 revealed Purpose: To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. Policy: Definition: An acute change of condition (ACOC) is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains. ?Clinically important' means a deviation that, without intervention, may result in complications or death. I. Members of the Interdisciplinary Team (IDT) are expected to report and document signs and symptoms that might represent and ACOC. II. The Facility will promptly inform the residents, consult with the residents' Attending Physician, and notify the resident's legal representative when the resident endures a significant change in their condition caused by, but not limited to: A. An injury/accident; B. A significant change in the resident's physical, cognitive, behavioral or functional status; C. A significant change in treatment; and/or D. A decision to transfer or discharge the resident from the facility.V. Family Notified A. The Licensed Nurse will notify the resident, the resident's responsible party, or the family/surrogate decision-makers of any changes in the resident's condition as soon as possible. VI. Documentation A. A Licensed Nurse will document the following: i. Date, time, and pertinent details of the incident and the subsequent assessment in the Nursing Notes.iii. The time the family/responsible person was contacted.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident had the right to personal privacy for personal care for one of five (Resident #105) residents observed for personal care. CNA N failed to provide privacy during incontinent care of Resident #105 on 04/13/26. The failure could affect residents, by placing them at risk for loss of privacy and dignity. The findings were: Record review of Resident #105's annual MDS assessment, dated 02/17/26, reflected an [AGE] year-old male who was admitted to the facility on [DATE], and readmitted on [DATE]. Resident #105 had diagnoses which included hypertension (high blood pressure), type 2 diabetes mellitus (high blood sugar), Cerebrovascular Accident (a medical emergency occurring when blood flow to the brain is interrupted (ischemic) or a vessel bursts (hemorrhagic), causing rapid brain cell death) ,non-Alzheimer's dementia (diseases that affect memory, thinking, and the ability to perform daily activities), and Hemiplegia or Hemiparesis (Hemiparesis refers to mild-to-moderate weakness, allowing some muscle movement. Hemiplegia is more severe, resulting in total paralysis or complete loss of movement control on one side). Resident #105 had a BIMS score of 05/15 which indicated Resident #105's cognition was severely impaired. Resident#105 was always incontinent for bowel/bladder. Record review of Resident #105's Comprehensive Care Plan dated 02/23/26 reflected the following: Focus: [Resident #105] has an ADL Self Care Performance Deficit r/t hemiplegia. Goal: [Resident #105] will improve current level of function in (Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene, ADL Score) through the review date. Personal hygiene: [Resident#105] requires sub/max level of assistance (where the helper does more than half the effort to complete an activity) with ADLs of oral and personal hygiene. Observation on 04/13/26 at 09:10 AM of CNA N performing incontinent care to Resident #105 revealed she closed the door but did not pull the privacy curtain around the bed. Resident #105 was in the first bed and his roommate was in the room. The roommate was up in his wheelchair watching TV in the middle of the room and going back and forth to his closet directly beside the room entrance. Resident #105's roommate had full view of the care CNA N provided to Resident #105. In an interview on 04/13/26 at 09:32 AM with CNA N confirmed the privacy curtain was not pulled all the way around the resident's bed and she stated it should be pulled for resident privacy, and dignity. CNA N stated she forgot to pull the curtain. Interview with the DON on 04/14/26 at 11:33 AM revealed staff were expected to close the door and pull curtains when providing resident care. The DON stated not pulling the curtain during incontinent care was a violation of Resident #105's rights to privacy and dignity. Review of the facility's policy revised August 2020 and titled Resident Rights revealed To promote and protect the rights of all residents at the facility. All residents have the right to dignified existence, self-determination, . The facility must treat each resident with respect and dignity and care for each resident in a manner and environment, that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assist residents in obtaining routine dental care for one of 8 residents (Resident #117) reviewed for dental services. The facility failed to ensure Resident #117 received routine dental services since admission on [DATE]. This failure could place residents at risk of difficulty with eating, decline in eating and a delay in treatment for dental services.Findings included Record review of Resident #117's face sheet undated reflected Resident #117 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (conditions characterized by paralysis or weakness on the right side of the body due to a stroke), dysphagia (difficulty swallowing), cognitive communication deficit and vascular dementia (significant symptoms of dementia that affect daily living). Record review of Resident #117's quarterly MDS assessment dated [DATE] reflected Resident #117 had a BIMS of 0 indicating he was severely cognitively impaired. Resident #117 required substantial/maximal assistance (level of assistance where the helper does more than half the effort to complete an activity) with ADLs of oral and personal hygiene. Resident #117 was on mechanically altered diet with no weight loss. Observation on 04/12/2026 at 12:55 PM with Resident #117 in his room revealed missing and broken teeth. Record review of Resident #117's electronic record did not reveal any completed dental care or assessments for Resident #117. Interview on 04/13/2026 at 3:00 PM with SW R and SW S revealed they were unable to locate any dental assessments for Resident #117. Both social workers were unaware he had not seen the dentist and were responsible for scheduling dental appointments. They stated they did not know why the resident had not received dental care nor assessments. They stated they would schedule Resident #117 on 04/14/26 for dental services to complete initial assessment for dental services. Interview on 04/14/2026 at 1:43 PM with Regional Social Worker revealed the facility was unable to locate any dental assessments for Resident #117. She stated moving forward they would review to ensure residents received and were set up for dental auxiliary services. Follow-up interview on 04/14/26 at 2:35 PM with Regional Social Worker revealed the potential risk for residents not receiving dental services can be pain or infection. She also stated there could be changes in a resident's eating or weight. Review of facility's policy Referrals to Outside Services revised 02/2025 reflected Social Services coordinates the referral of residents to outside agencies/programs to fulfill resident needs for services not offered by the facility. To facilitate this process, the facility maintains service provider contracts with a variety of providers.Examples of service provider contracts that Social Services may coordinate, but are not limited to dental services.