

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  45F945	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Southern Oaks Therapy and Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3350 Bonnie View Rd Dallas, TX 75216	

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)
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27070</p> <p>Based on observations, interviews, and record review, the facility failed to incorporate recommendations from a PASRR (Preadmission Screening and Resident Review) evaluation report into a resident assessment, care planning, and transition of care for one (Resident # 65) of one resident reviewed for PASRR services.</p> <p>The facility did not provide Habilitative Services (Physical Therapy, and Occupational Therapy) and Durable Medical Equipment(DME)/ Customized Wheelchair for Resident #65 per PASRR recommendations made at the Interdisciplinary Team (IDT) meeting held on 3/26/2024 within 20 days.</p> <p>This failure could place residents at risk of not receiving specialized PASRR services which would enhance their highest level of functioning and could contribute to residents decline in physical, mental, and psychosocial well-being.</p> <p>Findings included:</p> <p>Record review of Resident #65's quarterly MDS Assessment, dated 07/13/24, revealed he was admitted to the facility on [DATE] with diagnoses which included cerebral palsy (effects the nerves and muscle), intellectual disability, bipolar disorder, and scoliosis (curving pf the spine). Resident #65's BIMs score of 10 indicated the resident's cognition was moderately impaired, and able to make decisions for themselves.</p> <p>Record review of Resident #65's PASRR Comprehensive Service Plan Form, dated 03/26/2024, revealed a quarterly IDT/SPT meeting was held. The Specialized Services Information section revealed Resident #65 was to receive Habilitation Coordination. Under comments reflected, [Resident #65] will be using therapy services. The Specialized Services and Participation Confirmation indicated All DD Specialized Services to include customized Wheelchair, selected were agreed to by the IDT and the SPT agreed for Resident #65.</p> <p>Record review of Resident #65's revised care plan, dated 06/06/2024 with no updates, revealed Resident #65 had not received PASRR Habilitation services (PT, OT, and ST) for PASRR positive diagnosis of intellectual disability and the DME (customized wheelchair) had been recommended by PASSR was still not initiated at the meeting on 06/06/2024.</p> <p>(continued on next page)</p>

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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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/07/24 at 11:32 a.m. the MDS coordinator revealed that she placed all the information in the system for the PASRR I and PASRR II. The MDS coordinator said that she did attend the IDT meetings for Resident #65. The MDS coordinator said she was aware of the specialized services that had been recommended by the Habilitative Services Director. The MDS said she was responsible for filling out the paperwork for the recommendations and placing in the TMHP portal. The MDS coordinator was asked if Resident #65 had received the habilitative services recommended for therapy and the customized wheelchair. The MDS coordinator said that she knew that Resident #65 was not receiving habilitative therapy in their therapy department, and he had not received a wheelchair. The MDS coordinator said she had printed out the paperwork for the Director of Rehabilitation. The MDS confirmed that the resident wanted to live in the facility, and he thought he needed a wheelchair to be more independent, be safe, and allow him to be positioned in his chair properly.</p> <p>In an interview on 08/08/24 at 2:20 p.m. the Director of Rehabilitation(DOR) revealed she recalled attending the IDT meetings and the specialized services (habilitative therapy, specialized wheelchair) that had been recommended. When the DOR was asked about the customized wheelchair, she said the wheelchair has not been ordered, but the resident had a wheelchair. The DOR stated she had asked several times of the Administrator at that time, and he refused to let her order it or to call the DME company. The DOR stated the specialized wheelchair had been ordered, now that the new company had taken over and the DME company was coming out, since the bill had been paid. The DOR confirmed she had entered the required paperwork in the portal for the specialized wheelchair and PT, OT, and ST. The DOR said she had, but the paperwork had been denied, because the DME company did not come and supply the measurements for the wheelchair. She said she had followed-up, at least three times with the previous Administrator since March, until the new company came and ordered the wheelchair in July and offered to pay for it. The resident had not gotten up as often, because the resident felt the wheelchair provided to him is not for him, and it does not fit the resident correctly.</p> <p>In an interview on 08/06/24 at 1:15 p.m. the Habilitation Coordinator (HC) with the PASSR program revealed she had been involved in all the IDT meetings for Resident #65. The HC said on 03/26/24 the recommendations had been made for a customized wheelchair and habilitative rehab for PT, ST, and OT. Resident #65 had decided he wanted to have a customized wheelchair for better mobility. She followed up with the DOR and the MDS coordinator from 03/26/24 through 06/10/2024 multiple times, one time in April that she recalled and she was told the specialized wheelchair forms had been completed and the previous Administrator refused to allow the DME company to come out and complete the measurement. She informed the MDS coordinator and the DOR that she had no other choice, she was going to call a complaint into the state because of the length of time it was taking. The HC stated in July she was informed by the MDS coordinator that the new ownership had agreed to purchase the specialized wheelchair and allow the DME company to come and measure, and the habilitative therapy was to be started . The resident required a specialized wheelchair suitable for his diagnoses and enable him to learn how to use the chair safely so he can be active and have safe mobility.</p> <p>An observation and interview on 08/06/2024 at 8:00 a.m. revealed Resident #65 was in bed. When asked about his wheelchair, Resident #65 said he had a meeting back in March with a nurse, director of rehabilitation, and his case manager and he had agreed to have a specialized wheelchair and therapy. He had a wheelchair the facility gave him, it was new, but it was not specialized. He stated he was still waiting on his wheelchair. He was told by someone (unable to identify) with the new company that he would be getting his soon, because they had ordered it. He said, finally, he will be comfortable when he mobilized in his wheelchair. He stated he had not been comfortable in this wheelchair, so he did not get up that often.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 08/06/24 at 4:30 p.m. CNA E revealed Resident #65 could speak and knew what he wanted. CNA E said Resident #65 was very pleasant and when he got up, he used his wheelchair, but he sometimes did not get up because he did not like the wheelchair. CNA E stated the resident was waiting on his own wheelchair to come. When CNA A was asked about therapy, she said she did not recall what therapies the resident received, but she did not see the therapist go to the resident or the resident go to therapy.</p> <p>In an interview on 08/07/24 at 2:06 p.m. the Administrator stated, the previous administrator of the facility did not respond to the HC request to have Resident #65's specialized services started and Resident #65 measured through the DME company. The new Administrator stated it was the responsibility of the MDS coordinator and the DOR to monitor all PASRR residents and special service needs. The Administrator stated the new company had ordered the equipment and the DME company was coming to measure the resident. The Administrator said that the DOR had not asked for assistance from her to know how to prepare the paperwork for the TMHP. The new Administrator said that it was important to the resident to be able to maintain their level of function , instead of staying in his bed, in his room.</p> <p>In a phone interview on 08/08/2024 at 3:45 p.m. with the previous Administrator revealed he had not approved for Resident #65 to receive habilitative services or a specialized wheelchair, because the previous company was in bankruptcy, and he could not get the equipment and services paid for unless he paid for it himself.</p> <p>Record review of the PASRR Nursing Facility Specialized Services Policy and Procedure, revised 03/06/2019, reflected, .to ensure forms are submitted timely and accurately, Therapy, CMWC/DME is notified after the IDT meeting, the facility only has 20 business days from the date of the meeting to submit a completed and accurate form, the facility must order the DME within 5 business days after receiving approval.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070</b></p> <p>Based on observations, interviews, and record review the facility failed to review and revise the person-centered comprehensive care plan to reflect the resident's status, for 3 of 4 residents (Resident #52, #53, and Resident #65) reviewed for care plans.</p> <p>The facility did not update Resident #52's care plan to reflect goals and interventions for the discontinuation of the Condom Catheter.</p> <p>The facility did not update Resident #53's care plan to reflect goals and interventions for the change from a motorized wheelchair to a manual wheelchair.</p> <p>The facility did not update Resident #65's care plan to reflect goals and interventions for the PASRR meeting and the ordering of a specialized wheelchair and rehabilitative services.</p> <p>This failure could place residents at risk for not receiving appropriate care and intervention to meet their current needs.</p> <p>The findings were:</p> <p>Review of Resident #52's MDS annual assessment dated [DATE], reflected he was a [AGE] year-old male admitted on [DATE]. The resident diagnoses included: spastic quadriplegia (neuro-muscular disease not allowing movement), cerebral palsy (neuromuscular disease), and respiratory failure (failure to breath on his own for periods of time). He had a BIMs score of 99 which indicated the interview was not successful or not completed. He required maximum assist of two staff members for activities of daily living.</p> <p>Record review of Resident #52's Care Plan initiated on 02/14/24 reflected, it had been edited on 07/18/24, there was an updated problem listed for the incontinence reflected the condom catheter was ordered on 06/18/2024, with no revision to the plan goals specific for the condom catheter being discontinued on 06/21/24.</p> <p>Record review of the physician orders dated 06/2024 reflected Resident # 52's condom catheter had been discontinued on 06/21/2024 as it was not medically necessary.</p> <p>Review of Resident #53's MDS quarterly assessment dated [DATE], reflected he was a [AGE] year-old male admitted on [DATE]. His diagnoses included: hypertension (high blood pressure), diabetes (increase in blood sugar), Parkinson (neuromuscular disease), hemiplegia (loss of the use of one side of body), and dementia (confused). His BIMs score of 11 reflected his cognitive status was moderately impaired. He required moderate to maximum assist of two staff member for activities of daily living.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #53's Care Plan initiated on 10/12/22 reflected, the care plan had been edited on 07/03/24. There was no updated problem listed for the manual wheelchair or a revision to the care plan goals specific for the latest change from an electric wheelchair to a manual wheelchair due to safety on 03/27/24. The facility did not update Resident #53's care plan to reflect goals and interventions for the change from a motorized wheelchair to a manual wheelchair.</p> <p>Review of the Occupational therapy notes on 03/27/24 revealed Resident #53 was assessed for safety and positioning in his motorized wheelchair. The assessment referred to poor trunk control and therapy was initiated. Resident #53 did not improve with trunk control. The manual wheelchair was recommended for his safety as well another resident' safety.</p> <p>Review of Resident #65's MDS quarterly assessment dated [DATE], reflected he was a [AGE] year-old male admitted on [DATE]. His diagnoses included: cerebral palsy (neuromuscular disease), bipolar disorder (mental illness), scoliosis (curvature of the spine), hemiplegia (loss of the use of one side of body), and anxiety (anxious). His BIMs score of 10 reflected his cognitive status was moderately impaired. He required moderate to maximum assist of one staff member for activities of daily living.</p> <p>Record review of Resident #65's Care Plan initiated on 11/25/2020 reflected, the care plan had been edited on 06/06/24. There was no updated problem listed for a specialized wheelchair or habilitative services, or a revision to the care plan goals specific for the latest change from a standard manual wheelchair to a specialized wheelchair, which habilitative services recommended during the PASRR meeting on 03/26/2024. The facility did not update Resident #65's care plan to reflect goals and interventions for the change from a standard wheelchair to specialized wheelchair with habilitative therapy.</p> <p>In an interview on 08/08/2024 at 3:00 p.m. with MDS nurse revealed she updated the care plans. The MDS nurse stated the information was obtained through visiting with the staff, resident, checking progress notes, and the plan of care meetings. The MDS nurse stated she was unaware of Resident #53 having a manual wheelchair provided to him. The MDS nurse stated Resident #53 was going to therapy today (08/08/2024) in his motorized wheelchair. The MDS nurse stated that she was unaware he had a change in his mobility ability, she was going to meet with other department heads and update the plan of care. The MDS nurse stated she was unaware Resident #52 did not use a condom catheter, and Resident #65 was using a wheelchair the facility had provided him. The MDS nurse stated she did not think of documenting all the PASRR information on the plan of care.</p> <p>In an interview on 08/07/24 at 11:30 a.m. with the DON revealed, the MDS/care plan nurse should be aware of any changes with the residents. She stated we go over all the changes of resident's condition in the morning meetings. She would be able to update all care plans then. The DON completed sign offs on the MDS's as being completed and she did attend care plan meetings. The DON was aware Resident #52, #53, and Resident #65 had changes concerning care and mobility. The DON stated she was unaware if the care plans had been updated. The DON stated she did not follow-up on the plan of care. The DON stated if the care plans were not followed-up on appropriately then the staff would not know what the goals were. The DON stated the MDS/care plan nurse conducted and scheduled the meetings and the department heads all attend.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled Quarterly Review of Care Plans revised dated March 2022, reflected the following: .The Care Planning/Interdisciplinary Team is responsible for maintaining care plans on a current status .The Care Planning/Interdisciplinary Team is responsible for the periodic review and updating of care plans: When there has been a significant change in the resident's condition When the desired outcome is not meet When the resident has readmitted to the facility from a hospital stay; and At least quarterly.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070</b></p> <p>Based on observations, interviews, and record review, the facility failed to ensure all assistive devices were maintained and free of hazards for eight (Residents #2, #4, #5, #8, #11, #54, #55, and #158) of twelve residents reviewed for essential equipment and one of one clean utility room reviewed for hazards.</p> <p>The facility failed to ensure treatment supplies in the clean utility room on Hall 200 was secured or attended by authorized staff when unlocked.</p> <p>The facility failed to properly maintain wheelchairs for Residents #2, #4, #5, #8, #11, #54, #55, and #158.</p> <p>These failures could place residents at risk for equipment that was in unsafe operating condition, which could cause injury and/or resident access to harmful supplies leading to a risk for injury.</p> <p>Findings included:</p> <p>1. An observation on 08/06/24 at 9:00 a.m. revealed the clean utility room door on Hall 200 was left unlocked and the door was left open. There was a sign on the door stating, keep door closed and locked at all times when not in use.</p> <p>An observation of the supplies of the clean utility room on Hall 200 at 9:05 a.m. revealed the following supplies: suction equipment, nutritional gastronomy tube formulas (for using with residents who have feeding tubes), tubing for Foley's (tubing to allow urine to come out of body), Syringes (shots) with needles, twelve boxes of syringes 3cc and Tuberculin syringes, eight boxes of needles, a variety of catheters (latex tubing), Prostate ( medication for protein supplement), and Arginate (medications supplement for protein).</p> <p>An observation on 08/06/24 at 9:30 a.m. revealed the clean utility room door on Hall 200 was left unlocked and the door was left open.</p> <p>An observation and interview on 08/06/24 at 9:41 a.m. revealed the clean utility room door on Hall 200 was left unlocked and the door was left open. There was an unidentified staff member in the room removing a cleaning solution that had been left on the counter of the room. The unidentified staff member stated that the door should be closed and always locked, when not in use. They were not sure who had keys to the room. They stated that they had seen the cleaning solution in there earlier and thought they should get it, because it really did not belong in there.</p> <p>An observation on 08/06/24 at 10:30 a.m. revealed the clean utility room door on Hall 200 was left unlocked and the door was left open.</p> <p>An observation on 08/06/24 at 11:16 a.m. revealed the clean utility room door on Hall 200 was left unlocked and the door was left open. There was an unidentified resident getting paper towels and looking for Kleenex in the cabinets out of the clean utility room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 08/06/24 at 11:17 a.m. with the ADON revealed the clean equipment room on Hall 200 should be locked at all times, when not in use. The ADON stated the nurses have a key. The ADON could not explain why the supply room had been unlocked all morning. The ADON stated if any resident got supplies from this room they could be harmed. The ADON agreed that the items that were listed above observation were the items always kept in the room.</p> <p>In an interview on 08/07/24 at 4:00 p.m. with the DON revealed the supply room on Hall 200 should always been locked when not in use. If the residents were allowed to get into the supply room, it could cause danger and possible injury to the resident.</p> <p>2. Review of Resident #2's quarterly MDS assessment, dated 6/20/2024, reflected she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of dementia (confusion and forgetfulness), generalized weakness, and anxiety (nervousness). Resident #2 had a BIMs score of 07 indicating she was moderately cognitively impaired.</p> <p>Review of the Resident #2's plan of care dated 06/22/2024 with updates reflected goals and approaches to include wheelchair mobility for locomotion.</p> <p>Observation on 08/06/2024 at 7:45 a.m. revealed Resident #2 was sitting in her wheelchair in the front of the facility and had no skin problems. The wheelchair's left armrest cracked with exposed foam.</p> <p>Review of Resident #4's annual MDS assessment, dated 07/13/2024, reflected she was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses of paranoid schizophrenia (mental illness) and muscles weakness. Resident #4 had a BIMs score of 10 reflecting she was mildly cognitively impaired and able to make decisions for herself.</p> <p>Review of the Resident #4's plan of care dated 07/23/2024 with updates reflected goals and approaches to include wheelchair mobility for locomotion.</p> <p>An observation on 08/06/2024 at 12:05 p.m. revealed Resident #4 was sitting in her wheelchair in the dining room and had no skin problems. The wheelchair's right armrests were missing, and the left armrest was turned upside down and taped onto the wheelchair.</p> <p>An attempt to interview Resident #4 on 08/06/2024 at 12:05 a.m. revealed she was not interested in talking about her wheelchair.</p> <p>Review of Resident #5's annual MDS assessment, dated 07/24/24, reflected she was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses of paranoid schizoaffective (mental illness), muscle weakness (muscle deterioration), traumatic brain injury (brain injury), and diabetes (increase in your sugar level). Further review of the MDS reflected the resident was severely cognitively impaired and unable to make decisions for themselves.</p> <p>Review of the Resident #5's plan of care dated 07/27/24 with updates reflected goals and approaches to include wheelchair mobility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 08/06/24 at 12:20 p.m., revealed Resident #5 was sitting in her wheelchair in the dining room and the wheelchair's left and right armrests were cracked with exposed foam. There were no skin tears on the resident arms. The wheels of the wheelchair had dried food substance on both wheels and on wheel rims.</p> <p>Review of Resident #8's quarterly MDS assessment, dated 07/17/2024, reflected he was a [AGE] year-old male admitted to the facility on [DATE], with diagnoses of cardio-obstructive pulmonary disease (breathing problems), cancer, and muscle weakness. Resident #8 had a BIMs score of 15 reflecting he was cognitively alert, oriented, and able to make decisions for himself.</p> <p>Review of the Resident #8's updated plan of care dated 07/20/2024 with updates reflected goals and approaches to include wheelchair mobility.</p> <p>Observation and interview on 08/06/2024 at 12:07 p.m. revealed Resident #8 in his wheelchair sitting at the table in the dining room. Resident #8 stated that his arm rests were broken. The wheelchair's right and left armrests were cracked with exposed foam. The left armrest had tape around both ends of the armrest and was sidewise on the wheelchair. Resident #8 stated he had told the nurses that his wheelchair arms were broken, but nothing had been done. He stated that it was about three weeks ago that he thought that he told the staff, but he could not recall which staff member he told.</p> <p>Review of Resident #11's quarterly MDS assessment, dated 07/25/2024, reflected she was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses of hypertension (high blood pressure), cardiovascular accident (stroke), seizures (brain disorder), and unsteady on feet (instability). Resident #11 had a BIMs score of 9 reflecting she was moderately cognitively impaired and able to make decisions for herself.</p> <p>Review of the Resident #11's plan of care dated 07/27/2024 with updates reflected goals and approaches to include wheelchair mobility.</p> <p>Observation and interview on 08/06/2024 at 12:10 p.m. revealed Resident #11 sitting in her wheelchair, in the dining room Resident #11 revealed the wheelchair's left and right armrests were cracked with exposed foam. Resident #11 was asked about her wheelchair, and she stated, It was needing some work, and the wheelchair had been provided to her by the facility. There were no skin tears on the resident's arms.</p> <p>Review of Resident #54's quarterly MDS assessment, dated 06/27/24, reflected she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses of congestive obstructive disorder (respiratory ability to breath), congestive heart disease (heart disease), and right below knee amputation. Further review of the MDS reflected the resident was severely cognitively impaired and unable to make decisions for themselves.</p> <p>Review of the Resident #54's plan of care dated 06/30/24 with updates reflected goals and approaches to include wheelchair mobility for locomotion.</p> <p>Observation on 08/06/24 at 12:30 p.m., revealed Resident #54 was sitting in her wheelchair, in the dining room and had no skin problems. The wheelchair's right armrest was cracked with foam exposed. There were dried food substances on the back of the wheelchair.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Southern Oaks Therapy and Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3350 Bonnie View Rd Dallas, TX 75216	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident # 55's quarterly MDS assessment, dated 06/21/24, revealed an [AGE] year-old female admitted to the facility on [DATE]. Her diagnosis included dementia, delirium due to known physiological condition, generalized idiopathic epilepsy, repeated falls, and history of traumatic brain injury. The cognitive section C100 of the MDS indicated Resident #55 had severe cognitive impairment. She had symptoms of inattention, disorganized thinking, altered level of consciousness, and wandering. She had an unsteady gait and required a wheelchair for mobility.</p> <p>Record review of Resident #55's Care Plan dated 06/26/24, revealed with updates reflected goals and approaches to include wheelchair mobility for locomotion.</p> <p>Observation on 08/06/24 at 12:32 p.m., revealed Resident #55 was sitting in her wheelchair, in the dining room and had no skin problems. The wheelchair's right armrest was cracked with foam exposed. There were dried food substances on the back of the wheelchair.</p> <p>Review of Resident #158's quarterly MDS assessment, dated 05/22/24, reflected she was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses of hemi-left dominant side (cannot use that side), convulsions (seizures), abnormalities of gait and mobility (unable to mobilize safety), and depression (mental illness). Further review of the MDS reflected the resident was alert and oriented and able to make decisions for themselves.</p> <p>Review of the Resident #158's updated plan of care dated 05/24/24 with updates reflected goals and approaches to include wheelchair mobility.</p> <p>Observation and interview on 08/06/24 at 10:32 a.m., revealed Resident #158 was in her wheelchair in the hallway, and the wheelchair's right and left armrests were missing. The back of the wheelchair was frayed and had an open cracked back. There were no skin tears on the resident's arms. There were dried food particles in the cracked area of the back of the wheelchair. Resident #158 stated the back of the wheelchair did not bother her, but she would like to have some armrests on this wheelchair. She stated she did not want another wheelchair this one was big enough for her.</p> <p>In an interview on 08/06/2024 at 12:45 p.m. with RN B revealed that if one of the residents had a broken wheelchair, he would tell the DON. The RN stated he had only been working at the facility for ten days. The RN stated he did not think they had a maintenance person at the facility.</p> <p>In an interview on 08/07/2024 at 11:00 a.m. with LVN A revealed the nurse had no idea how to order or who to tell about new parts for a broken wheelchair. LVN A stated she had worked there since April, and no one had asked about wheelchairs or told her anything about a maintenance log. LVN A stated, she was unaware if there was a maintenance person.</p> <p>In an interview on 08/07/2024 at 9:00 a.m. with the Assistant maintenance person revealed he knew nothing about repair on any wheelchairs. The Assistant Maintenance person stated, the new Administrator that started working on the past Monday, had spoken to him about parts. The Assistant maintenance person stated, the Administrator told him there were going to be parts ordered and then the wheelchairs could be repaired. The Assistant maintenance person stated before the new Administrator came, no one had mentioned anything to him about broken wheelchairs or ordering parts. The Assistant maintenance person stated the Administrator had only been there two days, and there was no maintenance supervisor. The Assistant maintenance person stated if there were rough edges on the wheelchair, it could hurt the resident's skin.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 08/07/2024 at 10:00 a.m. with Administrator who had only been there two days, stated that was one thing she looked at on yesterday (08/06/2024) was wheelchairs. The Administrator stated there was a receipt provided of the equipment that had been ordered to repair wheelchairs. The Administrator stated wheelchairs and repair were a big concern for her, and she wanted them fixed with a program put in place, so all staff understood how to report the need for wheelchair repair.</p> <p>In an interview with the DON on 08/07/2024 at 11:00 a.m. revealed she was not aware of any wheelchairs that would require repairing.</p> <p>Review of the Maintenance logs for the past three months reflected there was no entries concerning repair of wheelchairs.</p> <p>Review of receipt of the wheelchair parts dated 08/07/2024 reflected fifteen different parts, including arm rests and backs ordered by the new administrator.</p> <p>A review of the facility's policy and procedure equipment-General Use for All Residents revision dated July 2012 reflected Policy Statement Our facility shall provide routine equipment for the general us of resident population. 1. Wheelchairs, Are maintained by our facility for the general use of all residents</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27070</b></p> <p>Based on observations, interviews, and record review, the facility failed to ensure that medications were secure and inaccessible to unauthorized staff and residents for one (Hall 500 ) of one treatment cart reviewed for prescribed treatment medication storage and one (Hall 200 clean utility room) of one clean utility room reviewed.</p> <p>The facility failed to ensure treatment supplies were secured or attended by authorized staff when LVN A's treatment cart for Hall 500 was left unlocked.</p> <p>The facility failed to ensure medical supplies were secured or attended by authorized staff when the clean utility room was left unlocked on Hall 200.</p> <p>This failure could result in resident access and ingestion of prescribed treatment medications and obtaining harmful supplies leading to a risk for harm and possible drug diversion.</p> <p>Findings included:</p> <p>An observation on 08/06/24 at 8:21 a.m. revealed the hall 500 treatment cart was left in the hallway outside of room [ROOM NUMBER] and unlocked. The room door was closed, and the treatment cart was not in direct site of the LVN in charge of the hallway.</p> <p>An observation and interview on 08/06/22 at 8:31 a.m. revealed LVN A walked out of the room [ROOM NUMBER] to the treatment cart on hall 500. The LVN immediately stated, she was so sorry the treatment cart should have been locked. LVN A stated she had come out of the room and had forgotten some supplies. The LVN stated after she obtained her supplies off the treatment cart and returned to the room forgetting to lock the cart. LVN A stated today (08/06/24) the charge nurses were responsible to complete their own treatment on the hallways and it was confusing to her, so this mistake was made. LVN A stated the treatment cart must always be locked, so the residents, staff, and visitors could not take the medications that were on the cart and be endangered.</p> <p>An observation on 08/06/24 at 9:00 a.m. revealed the clean utility room door on Hall 200 was left unlocked and the door was left open. There was a sign on the door stating, keep door closed and locked at all times when not in use.</p> <p>An observation of the supplies of the clean utility room on Hall 200 on 08/06/24 at 9:05 a.m. revealed the following supplies: suction equipment, nutritional gastrostomy tube formulas (for using with residents who have feeding tubes), tubing for catheters (tubing to allow urine to come out of body), a variety of catheters (latex tubing), Prostate ( medication for protein supplement), and Arginate (medications supplement for protein).</p> <p>An observation on 08/06/24 at 9:30 a.m. revealed the clean utility room door on Hall 200 was left unlocked and the door was left open.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation and interview on 08/06/24 at 9:41 a.m. revealed the clean utility room door on Hall 200 was left unlocked and the door was left open. There was an unidentified staff member in the room removing a cleaning solution that had been left on the counter of the room. The unidentified staff member stated that the door should be closed and always locked, when not in use. They were not sure who had keys to the room. They stated that they had seen the cleaning solution in there earlier and thought they should get it, because it really did not belong in there.</p> <p>An observation on 08/06/24 at 10:30 a.m. revealed the clean utility room door on Hall 200 was left unlocked and the door was left open.</p> <p>An observation on 08/06/24 at 11:16 a.m. revealed the clean utility room door on Hall 200 was left unlocked and the door was left open. There was an unidentified resident getting paper towels and looking for Kleenex in the cabinets out of the clean utility room.</p> <p>In an interview on 08/06/24 at 11:17 a.m. with the ADON revealed the clean utility room on Hall 200 should be always locked, when not in use. The ADON stated the nurses have a key. The ADON could not explain why the supply room had been unlocked all morning. The ADON stated if any resident got supplies from this room they could be harmed. The ADON agreed that the items such as: suction equipment, nutritional gastronomy tube formulas (for using with residents who have feeding tubes), tubing for catheters (tubing to allow urine to come out of body), Syringes (shots) with needles, twelve boxes of syringes 3cc and Tuberculin syringes, eight boxes of needles, a variety of catheters (latex tubing), Prostate ( medication for protein supplement), and Arginate (medications supplement for protein) were the items always kept in the room.</p> <p>An observation on 08/06/24 at 11:30 a.m. at the nurse's station revealed there was only one treatment cart for all halls.</p> <p>In an observation and interview on 08/06/24 at 11:30 a.m. with LVN A regarding items in the treatment cart revealed: for Resident #5 Myriocin Ointment (antibiotic ointment used for skin infections), and Resident #12 Fluorouracil 5 cream (chemotherapy for skin cancer). There were also general stock medications for treatments as listed: barrier cream (to treat skin excoriations), Hydrocortisone creams (atopic treatment for contact dermatitis), Santyl ointment (used to treat pressure ulcers), antimicrobial gel (for skin infections), Dakin's Solution (for treating pressure sores), Zinc oxide cream (for treating excoriation of the skin), A &amp; D ointment (for treatment skin tears), Derma Cleanse Disinfecting wipes (used for cleaning) and bottles of skin wound cleanser. All the packing of the prescribed treatment medications read harmful if ingested. When LVN A was asked if these were the residents' ordered treatment medications listed above, she replied 'yes.'</p> <p>In an interview on 08/07/24 at 4:00 p.m. with the DON revealed the treatment carts were just like the medication carts; they were to be locked when not in use. The DON stated the clean utility/supply room on Hall 200 should be locked when not in use. The DON stated there would be more in-services completed to remind the staff of the importance of drug security. If the residents were allowed to get into either the carts or the supply room, it could cause danger and injury to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 08/08/24 at 9:00 a.m., the Administrator stated it was her expectation that treatment carts should be locked when not in use. The Administrator stated that was basic nursing skills to know the treatment cart should have been locked when not in use, and the medications on the cart could be dangerous for the residents. When the Administrator was asked who was responsible to monitor the carts to ensure they were locked, she said that would be the staff that were using the carts.</p> <p>Review of the Policy and Procedure Storage of Medications revised April 2007 reflected, The facility stores all drugs and biologicals in a safe, secure and orderly manner . drugs and biologicals used in the facility are stored in locked compartments .only person authorized to prepare and administer medications have access to locked medications .Compartments (including not limited to, drawers, . carts . containing drugs and biologicals are locked when not in use .Unlocked carts are not left unattended .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47855</p> <p>Based on observations, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen, reviewed for food safety.</p> <p>1 The facility failed to ensure food items in the refrigerator, were labeled with the item description (handwritten or manufacturer's label), had the received by date, the opened date, and/or the consume by or expiration by dates (if opened, 72 hours per the facility's policy or the manufacturer's expiration date) stored in accordance with the professional standards for food service.</p> <p>2. The facility failed to ensure food items were thawed by, completely submerging the item under cold water (at a temperature of 70 degrees F or below) that was running fast enough to agitate and float off loose ice particles.</p> <p>These failures could place residents at risk for food-borne illness and cross contamination.</p> <p>Findings included:</p> <p>Observations of the Walk-in refrigerator on 08/06/24 at 08:19 AM revealed the following:</p> <p>On the left side top shelf a storage bag with a partially used block of cheese was observed. The storage bag of cheese was open. There was no labeling on the bag indicating what was in the bag, when it was placed in the bag, and when it should be used by.</p> <p>There were 2 other storage bags both with dry cereal with use by dates on the packages, that were observed that were not sealed. The storage bags with those items were dated with one date, a date opened, and no expiration date marked on the outside.</p> <p>Interview and observation on 08/06/2024 at 1:50 PM of the Kitchen revealed, while washing hands in the handwashing sink, there was a pan of chicken sitting in the large sink immersed in water. The chicken was still frozen, and the water was not running. Seconds later, the DM noticed the pan of chicken and yelled for the cook, she turned the water on and began to talk to the cook about leaving the water running over the thawing the chicken. The cook apologized for turning off the water and trying to thaw the chicken. The DM stated staff know that if they thaw food, the water must be running but her expectation was for them to thaw items in the refrigerator . The DM stated that she primarily does the labeling when food comes in. The cooks and dietary aides are responsible for relabeling items after they are opened and returned to the dry storage or refrigerator.</p> <p>Interview on 08/06/2024 at 1:55 PM the [NAME] stated that she forgot and turned off the water. She stated that she knew it should be under running water, but just turned the water off by habit . The cook stated she knows that she is supposed to label things that she uses and has anything left over. The cook stated she understands that people can get sick from food that is not handled correctly.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's Food Storage Policy, Date Revised February 2023, Food Storage: Cold Foods - Policy Statement; 5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. Food: Preparation Policy Statement: All foods are prepared in accordance with the FDA Food Code. Procedures: 5. The Cook(s) thaws frozen items that requires defrosting prior to preparation using one of the following methods: o Thawing in the refrigerator, in a drip-proof container, and in a manner that prevents cross-contamination; o Thawing the item in a microwave oven, then transferring immediately to conventional cooking equipment;</p> <p>o Completely submerging the item under cold water (at a temperature of 70 For below) that is running fast enough to agitate and float off loose ice particles; o Cooking directly from the frozen state, when directed.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>27070</p> <p>Based on observations, interviews, and record review, the facility failed to 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 one (CNA C) of two staff observed for infection control.</p> <p>CNA C failed to wash hands or use hand sanitizer after each change of soiled gloves and wash hands during incontinent care to Resident #52.</p> <p>MA D failed to cleanse scissors before and after usage when administrating lidocaine patches to Resident #153.</p> <p>This failure could place residents at risk for spread of infection through cross-contamination.</p> <p>Findings included:</p> <p>An observation of incontinence care on 08/06/24 at 11:25 a.m. revealed CNA C washed her hands in the resident's bathroom and donned clean gloves. CNA C positioned Resident #52 on his back. CNA C unfastened the resident's brief tabs and wiped the penis area with a disposable wipe, discarded the wipe, CNA C removed her gloves, and placed on a pair of new gloves and did not wash her hands, prior to placing on gloves. She then wiped the folds of Resident #52 abdomen and the folds of groin inguinal (abdomen) area using incontinent wipes. CNA C discarded the wipe and placed on a new pair of gloves without prior cleansing her hands. Resident #52 was turned and held the resident on his right side. CNA C cleaned the buttocks area, which was soiled from urine and a small amount of dried bowel movement, with a disposable wipe. CNA C then removed the soiled gloves and placed on a new pair of gloves without cleansing her hands. CNA C continued with care turning Resident #52 on his left side cleansing his buttocks of urine and dried bowel movement. CNA C changed her gloves and placed on a new pair of gloves without cleansing her hands. CNA C placed a clean brief under the resident's buttocks. Repositioned the resident, CNA C fastened the clean brief. CNA C covered the resident and told Resident #52 she was done. CNA C removed the soiled gloves, went into the bathroom, and washed her hands. CNA C left the room, taking the bagged dirty laundry out of the room.</p> <p>In an interview on 08/06/24 at 11:40 a.m., CNA C said she was to perform hand hygiene before and after the procedure and between changes of gloves. The glove changes should occur at the beginning and at the end of the incontinent care. She said she did not do it this time because she was nervous and talking. She stated the risk would be spread of infection.</p> <p>An observation on 08/07/24 at 8:35 a.m., MA D while preparing to administer lidocaine patches to Resident #153's knees. The MA removed the patches at the medication cart, reached into a personal bag obtaining scissors, cutting the tops off the package without cleaning the scissors before or after usage, and placing them back in the personal bag.</p> <p>In an interview on 08/07/2024 at 8:45 a.m. with MA D revealed the scissors were personal scissors. The MA stated she never thought about cleaning the scissors. She stated, I guess it could spread germs to the next resident, if I did not clean them.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 08/07/24 at 4:30 p.m., the DON stated the expectation was to perform hand hygiene and glove changes before and after any care, and any time after removing dirty gloves. If hands are visibly soiled clean with soap and water, otherwise can use hand sanitizer after every third glove change. She stated the risk of not performing hand hygiene, would be cross contamination. The DON stated she would be doing proficiency skills testing again starting next week.</p> <p>Review of the facility's policy Infection Prevention and Control Program revised July 2017, revealed, . the facility: provide staff with appropriate information and instruction about infection control . infection control training topics will include at least: a. standard precautions, including hand hygiene.</p> <p>Review of the facility's policy Handwashing/Hand Hygiene revised July 2012 revealed . this facility considers hand hygiene the primary means to prevent the spread of infection 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents, and visitors. 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand gel, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies 7. Use an alcohol-based hand rub . or soap and water for the following situations . h. before moving from a contaminated body site to clean body site during resident care; .m. after removing gloves . 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections .</p> <p>Review of the facility's policy Cleaning and Disinfection of Resident-Care Items and Equipment revised March 2022 revealed Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current recommendations for disinfections . c. non-critical items are those that come in contact with intact skin but not mucous membranes. (1) non-critical resident-care items include bedpans, blood pressure cuffs, scissors, computers, and crutches . d. Reusable items are cleaned and disinfected of sterilized between resident (e.g., stethoscopes durable medical equipment</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  45F945	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
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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)		
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>27070</p> <p>44021</p> <p>Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 2 (Halls 100 and 500) of 4 halls, the nursing station area, the Central Supply, and the dining area reviewed for environment.</p> <p>The facility failed to ensure that surfaces were clean and devoid of marring or defect, that handrails were in good repair, and that the flooring was in good repair near rooms residents #55, #56, #6, #10 the nursing station area, dining area, and the 500 hall.</p> <p>These failures could affect residents and the staff by placing them at risk for diminished quality of life due to lack of a well-kempt environment.</p> <p>Findings included:</p> <p>An observation on 8/8/24 at 10:10 AM revealed that a handrail had become separated from the wall near the Central Supply Room in the 500 hall. The top of the wooden railing had become separated from the wall exposing a 1-inch gap at the top of the railing from the wall.</p> <p>An observation on 8/8/24 at 10:12 AM revealed that a tile near the central Nursing Station area was loose from the concrete floor below the tile. The tile was offset from the bordering tiles creating small gaps where a buildup of a black substance could be seen.</p> <p>Another tile in the same corner was missing a 2 X 2-inch gap leaving the concrete below the tile exposed, a buildup of a black substance could be seen in the area where the missing tile was.</p> <p>An observation on 8/8/24 at 10: 14 AM in the facilities only dining area revealed that 5 tiles directly under a sign that read Soiled Dishes had become separated from the concrete below. The tiles were observed to be completely loose and could be moved with applied pressure. The concrete floor beneath the tiles were observed to have a buildup of a black substance.</p> <p>In an interview on 8/8/24 at 10:24 AM CNA F stated that she was aware of where the maintenance log was and that she had been instructed to write things that needed to be fixed in the facility there. She also stated that she had never thought to have written down anything about loose tiles or handrails in the maintenance book .</p> <p>In an interview on 8/8/24 at 10:29 AM CNA G stated that the maintenance log was located right around the corner next to the maintenance office. She stated that if something needed to be fixed right away, like a clogged toilet, she would tell her nurse or if the maintenance man was at the facility she would tell him directly. She stated that she was unaware of a handrail being loose in the 500 hall and that she had never reported the loose tiles to the maintenance tech. She guessed that it would be harder to keep the floor clean or sanitized if there were gaps in the tile .</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 8/8/24 at 10:37 AM Maintenance Tech stated that the staff were supposed to use the maintenance logbook to report issues in the facility, but most of the staff just tell him. He stated that they do not use any computer system and that he had 5 maintenance managers in the last 6 months. He stated that he had not been aware of the handrail being loose in the 500 hall but that he would go try to fix it immediately as it could pose a hazard to the residents. He stated that he did know about the loose tiles in the facility and that he was trying to get to it but had not been able to yet .</p> <p>In an interview on 8/8/24 at 11:48 AM the ADM stated that she was new to the facility but that she expected that the staff were to use the maintenance logbook to report physical failures in the facility, that way those failures would be listed so they were attended too. She stated that he had not been aware of the handrail in the 500 hall but that she would have it fixed presently as it could offer a hazard to the residents if they needed to use the handrail.</p> <p>Review of the facility Maintenance Log x 6 months could find no entries for loose tiles or the loose handrail.</p> <p>Review of facility's policy Environmental Services Safety Procedures implemented 01/01/23 reflected to ensure general safety procedures are followed in the course of performing housekeeping and/or laundry duties. The policy</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>27070</p> <p>Based on observations, interviews, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests for five (Halls 100, 200, 300, 400, 500 nurse's station, kitchen conference room break room, and the main dining room), of five halls reviewed for pest control program.</p> <p>The facility had live flies and gnats in areas of the facility including the nurse's station, Halls 100, 200, 300, 400, 500, conference room, break room, and the main dining room.</p> <p>This failure could place residents at risk for spread of infection, cross-contamination, and decreased quality of life.</p> <p>Findings included:</p> <p>An observation on 08/06/24 at 8:00 a.m. revealed two live flies were in the conference room, one on the wall by the television and one on the window seal.</p> <p>An observation on 08/06/24 at 8:25 a.m. revealed two live house flies in the dining room that crawled on the left-over eggs. The food had been left in the dining room after breakfast had been served. Several gnats were observed around the glass of left over juice on the table. A fly was also observed crawling on the back of the medication cart in the dining room.</p> <p>An observation on 08/06/24 at 8:43 a.m. revealed three gnats and two flies flying around the conference room.</p> <p>An interview on 08/06/24 at 8:26 a.m. with MA D revealed the flies and gnats were bad. The MA stated she thought the files and gnats came in the front and the back doors. The MA stated she had told the housekeeping staff that there were so many flies and gnats, but they did not know what to do. She stated there was nowhere to report the sightings, no book, and she had not seen a pest control person at the facility to tell. MA D stated she did not know what else to do, she was not sure who to tell.</p> <p>An observation on 08/06/24 at 8:15 a.m. 3-4 live houseflies were observed in the kitchen. They were flying throughout the kitchen, around the food preparation areas and the sink area</p> <p>An observation on 08/07/24 at 8:20 a.m. on Hall 400, of Resident #154 with MA D revealed while giving medication to the resident a fly was flying around the resident's head. The MA was swatting at the fly. The resident would not comment about the fly. MA D stated, I told you yesterday the flies were everywhere.</p> <p>An observation on 08/06/24 at 8:30 a.m. on Hall 200 revealed two gnats in the sink of the supply room.</p> <p>An observation on 08/06/24 at 8:39 a.m. revealed a live fly on the wall of Hall 300 near the fire doors.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An observation on 08/06/2024 at 9:45 a.m. on Hall 100 revealed three flies flying down the hallway.</p> <p>An observation on 08/06/24 at 10:45 a.m. there was a fly crawling across the top of the nurse's station.</p> <p>An observation on 08/06/2024 at 12:00 p.m. revealed during the lunch, meal service there were 3 to five flies that were flying about the dining area as the residents were served their meals.</p> <p>An observation on 08/06/24 at 1:25 PM revealed 3-4 two liveflies were in the kitchen landing on food preparation surfaces.</p> <p>An observation on 08/08/2024 at 11:45 AM 2-3 live flies were observed in the food preparation areas during food holding temperature observations. The Flies were observed flying all over the food holding areas.</p> <p>An Interview on 08/06/24 at 1:25 PM with Dietary Manager revealed the facility did everything they can to keep the flies out but they are still in the kitchen. The Dietary Manager stated the facility had traps and pest control coming out but the flies are still in the kitchen.</p> <p>In a confidential group meeting on 08/07/2024 with 5 residents revealed the flies and gnats were still a problem. The residents stated the flies and gnats have not gotten any better in the last six months but had gotten worse. The new Administrator said the flies and gnats were going to be taken of.</p> <p>Observation and interview on 08/08/24 at 11:00 a.m. with LVN A at the nurse's station revealed there were no pest control log of communication in the computer system. The flies had been bad since I started working here in April, they were everywhere, there were two gnats around my treatment cart this morning I had to just keep swatting at them. The nurses just swat at the flies and the gnats, they were so annoying. LVN A stated she had asked about having a fly swatter at the nurses stion, but I was told I could not have one . LVN A stated the flies could cause carrying disease to residents.</p> <p>Interview on 08/08/24 at 11:04 a.m. with RN B revealed he had only worked at the facility for ten days. RN B stated he had seen flies and gnats everywhere. He swatted the flies or gnats and moved on. He had not reported the fly and gnat situation to anyone and he did not know who to report to . RN B stated flies were dirty, carried diseases.</p> <p>In an interview on 08/07/24 at 10:00 a.m. with Administrator revealed she was aware of the fly and gnat problem. The Administrator stated she called the pest control company today (08/07/24). The Administrator stated she had informed the pest control company she wanted a visit today (08/07/24).</p> <p>(continued on next page)</p>		

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