STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675081	A. Building B. Wing	03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Acres Living and Rehabilitation Center	2525 Centerville Rd Dallas, TX 75228

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 - Few	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 observations, interviews, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life for two (Resident #1 and Resident #2) of 5 residents reviewed for dignity.The facility failed to ensure Speech Therapist and LVN did not stand in front of Resident #1 and Resident #2 while feeding the residents during lunch meal on 03/09/26. These failures could place the residents at risk of not having the right to a dignified existence.Findings included: Resident #1Record review of Resident #1's Face Sheet, dated 03/09/2026, reflected a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with major depressive disorder (a serious mental health condition and low self-esteem), type 2 diabetes (a chronic condition where the body resist insulin or fails to produce enough, causing high blood sugar levels), dementia (general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), dysphagia (difficulty swallowing), and anxiety disorder (serious persistent mental health conditions characterized by excessive, uncontrollable worry and fear that interfere with daily life). Record review of Resident #1's Quarterly MDS Assessment, dated 02/07/2026, reflected the resident had severe impairment (more than a minimal restriction on a person's ability to engage in basic activities) in cognition with a BIMS score of 00. The Quarterly MDS Assessment did not have an eating or feeding assessment. Record review of Resident #1's Comprehensive Care Plan, dated 06/25/2025, reflected the resident had a focus for potential nutritional problems and functional decline secondary dysphagia. The goal was to maintain adequate nutritional status as evidenced by maintaining weight with no s/sx of malnutrition. The intervention was that diet be as ordered by the physician, honor resident rights to make personal dietary choices. Provide a calm, quiet setting at mealtimes with adequate eating time. Resident #2Record review of Resident #2's Face Sheet, dated 05/09/2026, reflected a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving cells of oxygen and nutrients), dysphagia (difficulty swallowing), schizoaffective disorder (a chronic mental health condition characterized by a combination of schizophrenia symptoms -such as hallucinations, delusions, and disorganized thinking).Record review of Resident #2's Quarterly MDS Assessment, dated 01/16/2026, reflected that the resident was rarely understood to determine the BIMS score. The Quarterly MDS Staff Assessment indicated that the resident was severely impaired. The Quarterly MDS Assessment indicated that the resident was dependent on staff for eating. Record review of Resident #2's Comprehensive Care Plan, dated 05/27/2025, reflected the focus was on ADL self-care performance deficit r/t cognitive and functional decline and confusion. The goal was to maintain current level of function in eating. Intervention was to require staff participation-substantial/maximal assistance.Observation on 03/09/26 at 1:30 PM revealed the Speech Therapist was standing while she fed Resident #1 her entire meal. LVN-A was observed standing while she fed Resident #2 her entire meal.In an interview on 03/09/26 at 2:38 PM the Speech Therapist stated she had known for over one year that it was a (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dignity issue to stand and feed a resident. She stated that the dining room was full and Resident #1 would become disruptive if she was not given her lunch timely. She stated that she should have asked another staff member to get a chair for her to sit. She stated that Resident #1 was at risk of choking or she would have to lean down to ensure that she was swallowing properly, and dignity. In an interview on 03/09/26 at 2:42 PM the DON stated the staff were expected to sit at the same level as the residents when feeding. She stated that the Speech Therapist was conducting a swallowing evaluation when she was feeding Resident #1. She stated she did not know if the LVN knew that she should not be standing while feeding Resident #2. She stated that residents were at risk of choking and not having dignified experience during their meal. The DON stated the facility did not have a feeding policy. In an interview on 03/09/26 at 2:50 PM LVN-A stated was not aware that she should not stand while she fed Resident #2. She stated risk to the resident was that she could have choked or felt intimidated when she was standing over the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 observations, interviews, and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 5 residents (Residents # 1, 2, and 3) reviewed for infection control in that:. The Speech Therapist touched her hair two times without using hand sanitizer while feeding Resident #1. The LVN-A touched her hair while feeding Resident #2, then she moved to assist Resident #3 with her meal, she did not sanitize her hands when she moved between the residents. This failure could place residents at risk of exposure and/or possible transmission of communicable diseases and infections. Findings included: Resident #1Record review of Resident #1's Face Sheet, dated 03/09/2026, reflected a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with major depressive disorder (a serious mental health condition and low self-esteem), type 2 diabetes (a chronic condition where the body resist insulin or fails to produce enough, causing high blood sugar levels), dementia (general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), dysphagia (difficulty swallowing), and anxiety disorder (serious persistent mental health conditions characterized by excessive, uncontrollable worry and fear that interfere with daily life). Record review of Resident #1's Quarterly MDS Assessment, dated 02/07/2026, reflected the resident had severe impairment (more than a minimal restriction on a person's ability to engage in basic activities) in cognition with a BIMS score of 00. The Quarterly MDS Assessment did not have an eating or feeding assessment. Record review of Resident #1's Comprehensive Care Plan, dated 06/25/2025, reflected the resident had a focus for potential nutritional problems and functional decline secondary dysphagia. The goal was to maintain adequate nutritional status as evidenced by maintaining weight with no s/sx of malnutrition. The intervention was that diet be as ordered by the physician, honor resident rights to make personal dietary choices. Provide a calm, quiet setting at mealtimes with adequate eating time. Resident #2Record review of Resident #2's Face Sheet, dated 05/09/2026, reflected a [AGE] year-old female admitted on [DATE]. The resident was diagnosed with vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving cells of oxygen and nutrients), dysphagia (difficulty swallowing), schizoaffective disorder (a chronic mental health condition characterized by a combination of schizophrenia symptoms -such as hallucinations, delusions, and disorganized thinking).Record review of Resident #2's Quarterly MDS Assessment, dated 01/16/2026, reflected that the resident was rarely understood to determine the BIMS score. The Quarterly MDS Staff Assessment indicated that the resident was severely impaired. The Quarterly MDS Assessment indicated that the resident was dependent on staff for eating. Record review of Resident #2's Comprehensive Care Plan, dated 05/27/2025, reflected the focus was on ADL self-care performance deficit r/t cognitive and functional decline and confusion. The goal was to maintain current level of function in eating. Intervention was to require staff participation-substantial/maximal assistance.Resident #3Record review of the face sheet dated 03/09/26 for Resident #3 reflected she was an 89 -year-old-female admitted to the facility 04/30/25. She was diagnosed with Alzheimer's Disease (a progressive, incurable neurodegenerative disorder), cognitive communication deficit (difficulty with verbal or non-verbal communication caused by underlying cognitive deficits). Record review of Quarterly MDS dated [DATE] for Resident #3 She had a BIMS score of 00 indicating severe impairment.Record review of care plan dated 05/01/25 for Resident #3 reflected a focus that she had potential nutritional problems. The goal was to maintain nutritional status. Intervention was to provide diet as ordered by the physician, regular diet with thin liquids. Observation on 03/09/26 at 1:30 PM revealed the Speech Therapist was feeding Resident #1 and touching her hair. She continued to feed Resident #1 and did not use hand sanitizer. LVN was observed touching her hair while she fed Resident #2, and she did (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not use hand sanitizer prior to continuing to feed Resident #2. LVN then moved to another table to assist Resident #3 to eat her meal, she did not sanitize her hands between residents.In an interview on 03/09/26 at 2:38 PM the Speech Therapist stated she was not aware that she had touched her hair while she was feeding Resident #1. She stated that she should have used hand sanitizer after she touched her hair before she continued feeding Resident #1. She stated she had received in-service training on infection control, but she did not remember the date. She stated that Resident #1 was at risk of infection when she did not sanitize her hands after touching her hair. In an interview on 03/09/26 at 2:42 PM the DON stated the staff were expected not to touch their hair while they were in the dining room feeding residents. She stated the staff were expected to sanitize their hands between assisting residents. She stated both the Speech Therapist and the LVN should have known to practice infection control. She stated that residents were at risk of infection when the staff touched their hair while they fed the residents. She stated she did in-service on infection control yearly on the computer in October and she also tried to do them in person monthly. She stated that Resident #1, Resident #2 and Resident #3 were at risk of infection when the LVN did not sanitize her hands between residents. In an interview on 03/09/26 at 2:50 PM LVN-A stated she did not use hand sanitizer when she fed Resident #2. She stated that she was not aware that she touched her hair while she fed Resident #2. She stated that she had sanitizer gel available and she just did not use it. She stated that she should have sanitized her hands prior to assisting Resident #3 and prior to returning to Resident #2. She stated that her actions placed both residents at risk of infection. Record review of hand hygiene policy dated August 2024 reflected, This facility considers hand hygiene the primary means to prevent the spread of infections. 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.4. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:p. Before and after assisting a resident with meals; and