

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675081	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Golden Acres Living and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 provide the necessary services for residents who were unable to carry out activities of daily living to maintain good grooming and personal hygiene for 7 residents (Resident #3, Resident #54, Resident #65, Resident #69, Resident #103, Resident #134, Resident #169) of 12 residents reviewed for ADLs. The facility failed to ensure:1- Resident #3, Resident #54, Resident #69, Resident #134, and Resident #169 had their fingernails trimmed and cleaned.2- Resident #65 and Resident #103 had their fingernails trimmed. These failures could place residents who were dependent on staff for ADL care at risk of loss of dignity, risk for infections and a decreased quality of life.Findings include:1.Record review of Resident #3's MDS assessment dated [DATE] reflected he was an [AGE] year-old male with an admission date of 10/25/2024. His diagnoses included unspecified Dementia (memory loss), cognitive communication deficit (difficulty in communicating). Resident #3 had a BIMS score of 0 indicating severe cognitive impairment. Resident #3 was dependent on ADL care for personnel and toileting hygiene.Record review of Resident #3's care plan with a revision date of 11/12/2024 reflected he was at risk for impaired cognitive function/dementia or impaired thought process, intervention: need assistance with all decision making, Resident #3 had an ADL selfcare performance deficit related to Dementia.Observation and interview on 01/20/2026 at 11:02 AM with Resident #3 revealed he was sitting in his wheelchair in the common area wearing a helmet. Resident #3 had approximately 0.25-0.3 centimeters long fingernails on both hands and dark residue under the fingernails, he stated he would like it to be trimmed and cleaned.2. Record review of Resident #54's MDS assessment dated [DATE] reflected he was a [AGE] year-old male with an admission date of 4/17/2024. His diagnoses included unspecified Dementia (memory loss), cognitive communication deficit (difficulty in communicating). Resident #54 had a BIMS score of 3, indicating severe cognitive impairment. Resident #54 needed moderate assistance with ADL care for personal and toilet hygiene.Record review of Resident #54's care plan with a review date of 04/18/2024 reflected he was at risk for ADL selfcare performance deficit, intervention: staff assist with all ADLs. Observation and interview on 01/20/2026 at 11:14 AM revealed Resident #54 was sitting in his wheelchair in the common area, Resident #54 had approximately 0.2 -0.3 centimeters long fingernails on both hands and dark residue under the fingernails. Resident #54 stated he would like it to be trimmed and cleaned.3. Record review of Resident #65's MDS assessment dated [DATE] reflected he was a [AGE] year-old male with an admission date of 10/06/2025. His diagnoses included unspecified Dementia (memory loss), cognitive communication deficit (difficulty in communicating). Resident #65 had a BIMS score of 3 indicating severe cognitive impairment. Resident #65 needed supervision with ADL care for toileting hygiene. Record review of Resident #65's care plan with a revision date of 10/14/2025 reflected he was at risk for impaired cognitive function/dementia or impaired thought process, intervention: need assistance with all decision making, Resident #65 had an ADL selfcare performance deficit related to Dementia. Observation and interview on 01/20/2026 at 11:00 AM revealed Resident #65 was sitting in his wheelchair in the common area. Resident #65 had approximately 0.25-0.3 centimeters long fingernails on both hands. He stated he liked it to be trimmed. 4. Review of Resident #69's Quarterly MDS (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675081	Facility ID: 675081 If continuation sheet Page 1 of 14

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment dated [DATE] reflected, Resident #69 was an [AGE] year-old female admitted to the facility on [DATE]. Her pertinent diagnoses included the following: Dementia, Psychotic disorder, Depression, Respiratory failure (lungs cannot oxygenate blood or remove carbon dioxide effectively), Cognitive communication deficit (difficulty with talking, listening, reading, or writing), generalized muscle weakness. Her BIMS score was 3, which indicated Resident# 69 had severe cognitive impairment. Resident #69 required moderate assistance with personal hygiene.Review of Resident #69's Comprehensive Care Plan, revised 7/27/25 reflected, Focus:[Resident #69 had] ADL Self Care Performance Deficit related to Impaired balance, Dementia. Interventions.Personal Hygiene Routine: Requires [one] staff assistance.In an observation and interview on 01/20/2026 at 11:10 AM with Resident #69 revealed , she had long, dirty fingernails on both hands. The nails on both hands were approximately 0.25-0.3 centimeter in length extending from the tip of her fingers. The nails were discolored tan and the underside had dark brown colored residue. Resident #69 stated she would like her nails to be cleaned.5. Review of Resident #103's Quarterly MDS assessment dated [DATE] reflected, Resident #103 was an [AGE] year-old female admitted to the facility on [DATE]. Her pertinent diagnoses included the following: Alzheimer's disease (a progressive brain disorder causing gradual decline in memory), Depression, Anxiety, Dementia. Her BIMS score was 0, which indicated Resident# 103 had severe cognitive impairment. Resident #103 was dependent on staff for her personal hygiene.Review of Resident #103 's Comprehensive Care Plan, revised 5/14/2025 reflected, Focus: [Resident #103 had] ADL Self Care Performance Deficit related to Dementia. Interventions: . Encourage to participate to the fullest extent possible with each interaction.Observation and Interview on 1/20/2026 at 11:26 AM with Resident #103 revealed Resident #103 had long nails, about 0.2-0.3 centimeters long and jagged. Resident #103 was not interviewable. LVN A stated that Resident #103 had long nails and will try to clip them after some time.6. Record review of Resident #134's MDS assessment dated [DATE] reflected he was a [AGE] year-old male with an admission date of 11/19/2024. His diagnoses included unspecified Dementia (memory loss), cognitive communication deficit (difficulty in communicating). Resident #134 had a BIMS score of 0 indicating severe cognitive impairment. Record review of Resident #134's care plan with a revision date of 11/21/2024 reflected that he was at risk for impaired cognitive function/dementia or impaired thought process related to encephalopathy, ADL selfcare deficit related to epilepsy and dementia. Observation and interview on 01/20/2026 at 11:38 AM revealed Resident #134 was walking through the hallway. Resident #134 had approximately 1-1.5 centimeters long fingernails on both hands. The nails were discolored tan and the underside had dark brown colored residue. Resident #134 stated he would like it to be trimmed and cleaned. 7. Record review of Resident #169's MDS assessment dated [DATE] reflected he was a [AGE] year-old male with an admission date of 11/26/2025. His diagnoses included Other cerebral infraction due to occlusion or stenosis of small artery (Stroke), Dementia in other diseases classified elsewhere (memory loss). Resident #169 had a BIMS score of 0 indicating severe cognitive impairment. Resident #169 needed substantial assistance with ADL care for toileting hygiene. Record review of Resident #169's care plan with a revision date of 12/05/2025 reflected he was at risk for impaired cognitive function/dementia or impaired thought process. ADL selfcare performance deficit due to Dementia. Observation and interview on 01/20/2026 at 11:28 AM revealed Resident #169 was sitting in his wheelchair in the common area. Resident #169 had long fingernails on both hands and dark residue under the fingernails. Resident #169 stated he would like it to be trimmed and cleaned.Interview on 01/20/2026 at 11:28 AM with LVN A stated that Nurses and CNAs were responsible for clipping and cleaning nails. He stated that for diabetic residents, nails should be clipped by nurses. He stated that CNAs performed nail care on residents on shower days and as needed. He added that he had not heard about any refusals for nail care on Resident #103 or Resident #69. LVN A stated he will offer nail care to both residents after the interview. He stated the risk of long and dirty nails were lapses in infection control.Interview on 01/20/2026 at 11:41 AM with CNA B stated that CNAs were responsible for nail care including trimming and cleaning them, unless the (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident had diabetes. She stated that nailcare was provided on shower days and as needed. She stated that Resident #103 and Resident #69 both had dementia but were not resistive to care. She stated that risk of dirty, long nails increased risk of infection. Observation on 1/20/2026 at 12:15 PM with Resident #103, revealed resident fingernails were clipped and filed on both hands. In an interview on 01/20/2026 at 11:41 AM with CNA G revealed Nurses and CNAs were responsible to provide nailcare on shower days and as needed, nurses cut the nails for diabetic residents. She stated all the residents in the memory care unit agreed to cut nails, even if they refused during the first attempt. She stated residents were at risk for skin tears and infections if they had long/dirty fingernails. In an interview on 01/20/2026 at 11:52 AM with LPN J revealed he was the charge nurse, CNAs and nurses were responsible to provide nailcare on shower days and as needed, nurses cut the nails for diabetic residents. He stated residents were at risk for skin tears and infections if they had long/dirty fingernails. He stated if a resident refused nail care, it was care planned and none of the residents identified were known to refuse nail care. He stated he will make sure all residents with long fingernails will be trimmed as soon as possible. In an interview on 01/20/2026 at 12:04 AM with CNA H revealed CNAs and nurses were responsible to provide nailcare on shower days and as needed, nurses cut the nails for diabetic residents. She stated residents were at risk of skin tears and infections if they had long/dirty fingernails. She stated all the residents in the memory care unit agreed to cut nails, even if they refused during the first attempt. In an interview on 01/20/2026 at 02:43 PM with LVN K revealed all nursing staff were responsible for providing nailcare on shower days and as needed, nurses cut the nails for diabetic residents. She stated residents were at risk of skin tears and infections if they had long/dirty fingernails. She stated all the residents in the memory care unit agreed to cut nails, even if they refused during the first attempt. In an interview on 01/20/2026 at 03:11 PM with CNA I revealed all CNAs and LVNs were responsible for providing nailcare on shower days and as needed, nurses cut the nails for diabetic residents. She stated residents were at risk of skin tears and infections if they had long/dirty fingernails. She stated all the residents in the memory care unit agreed to cut nails, even if they refused during the first attempt. In an interview on 1/22/26 at 10:20 AM with ADON C revealed her expectation was that Nurses and CNAs provided nailcare on shower day and as needed. She added that nurses should cut nails for diabetic residents. She stated that as a ADON in the facility, all nursing Mangers, including the DON conducted daily rounds on their residents. She added that the risk of long, dirty nails was skin issues related to scratching and increased infection control. In an interview on 01/22/2026 at 9:49 AM with the DON revealed her expectation was that nail care should be provided as needed, especially during shower time. She stated that CNAs were responsible for doing nail care unless the resident had a diagnosis of diabetes. She stated the charge nurses were supposed to monitor. She stated that if a resident refuses, CNAs should inform charge nurses. If resident continues ADL care denials, Nurses notify family members for the resident. The DON stated residents having long and dirty fingernails could be an infection control issue, dignity, and skin issues. The DON stated that in order to maintain quality of life in the facility, she and Nursing management staff conducted daily rounds on all residents and any changes in condition or care refusals, if any were discussed in the clinical meeting. She stated that risk of long, dirty fingernails was skin integrity concerns. In a follow-up interview on 01/22/2026 at 10:31 AM with the DON, she stated that the facility did not have any specific policy on fingernails. Record review of the facility policy titled ADL, Services to carry out, revised 07/2015 revealed It is the policy of this facility that residents are given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care. 2. If a resident is unable to carry out activities of daily living, the necessary services to maintain. grooming, and personal hygiene will be provided by qualified staff .		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide pharmaceutical services to ensure the accurate acquiring, receiving, dispensing, administering, and securing of medications for 3 medication cart (Medication nurse cart [NAME] Hall, medication aide cart Hall [NAME] Tower 1, and Medication Nurse cart Hall [NAME] Tower2) of 7 medication carts reviewed for pharmacy services and 2 Medication room (Medication room for [NAME] Hall, and the medication room for Hall [NAME] 1 Tower) of 4 medications rooms. The facility failed to ensure medications in unsecure containers were immediately removed from stock. The facility failed to ensure expired medication (two antibiotic solution bags) were not in the refrigeration. These failures could place residents at risk of not having the medication available due to possible drug diversion and at risk of not receiving the intended therapeutic benefit of the medication. Findings included: Record review on 01/20/26 of order summary dated 01/02/26 for Resident#174 revealed Ertapenem Sodium Injection solution Reconstituted use 500 mg intravenously one time a day for surgical wound 500 mg/100 ml to run over 30 minutes, and order summary dated 01/12/26 for Resident#174 revealed Ertapenem Sodium Injection solution Reconstituted use 1 gm intravenously one time a day for surgical wound 1gm 9gram/100 ml (milliliter) to run over 30 minutes Observation and interview on 01/20/26 at 09:46 AM revealed Resident #174's two bags of antibiotic solution (Ertapenem Sodium Injection solution Reconstituted use 500 mg intravenously) were in the refrigerator in Medication room for [NAME] Hall, both dated 01/03/26 with a red label do not use after: 01/05/26. RN R stated she did not know that the antibiotic expired, and she would take the two bags of antibiotic medications and dispose of them. She stated the nurses were responsible to check the refrigerator daily and get rid of expired medications according to facility policy. RN R stated Resident #174's antibiotic medication order was changed, and someone could give him the wrong dose and expired medication. Observation on 01/20/26 at 09:56 AM of the Medication Nurse Cart Hall [NAME] revealed the blister pack for Resident #15's Tramadol 50 mg (milligrams) tablet (controlled medication used for anxiety) had 2 blisters (blister#16 and blister#25) seal broken and the pills were still inside the broken blisters. In an observation and interview on 01/20/26 at 9:58 AM, of the Medication Nurse Cart Hall [NAME] RN R stated the night shift nurse pulled the medication from the blister#25 to give it to Resident#15, but the resident left for dialysis, and the nurse put the pill back in the blister to be given to Resident when she was back from dialysis. RN R was unaware when the blister#16 pack seal was broken, and she was not aware of who might have damaged the blisters. She stated the risk of a damaged blister and medications left in it would be potential for drug diversion. She stated the nurses and medication aides were responsible for checking the medication blister packs for broken seals during the count of narcotics during the change of shift. She stated the count was done at shift change and the count was correct. She stated she did not see the broken blisters during the count. She stated when a broken seal was observed, two nurses should discard the medication. An observation on 01/20/26 at 10:13 AM of the Medication Aide Cart Hall [NAME] 1 tower revealed the blister pack for Resident #120's Tramadol 50 mg (milligrams) tablet (controlled medication used for anxiety) had 1 blister (blister#1) seal broken and the pill was still inside the broken blister. The blister pack for Resident #132's Lorazepam 1 mg tablet (controlled medication used for anxiety) had 1 blister (blister#8) seal broken and the pill was still inside the broken blister. The blister pack for Resident #135's Zolpidem 6.25 mg tablet (controlled medication used for sleep aide) had 1 blister (blister#13) seal broken and the pill was still inside the broken blister. In an observation and interview on 01/20/26 at 10:17 AM, of the Medication Aide Cart Hall [NAME] 1 tower with MA Q revealed she was unaware when the blister pack seals were broken, and she was not aware of who might have damaged the blisters. She stated the risk of a damaged blister would be drug diversion. She stated the nurses and medication aides were responsible for (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	checking the medication blister packs for broken seals during the count of narcotics during the change of shift. She stated the count was done at shift change and the count was correct. She stated she did not see the broken blisters during the count. She stated when a broken seal was observed, two nurses should discard the medication. An observation on 01/21/26 at 1:20 PM of the Medication Nurse Cart Hall [NAME] 2 tower revealed the blister pack for Resident #2's Lorazepam 0.5 mg (milligrams) tablet (controlled medication used for anxiety) had 1 blister (blister#14) seal broken and the pill was still inside the broken blister. In an observation and interview on 01/21/26 at 1:22 PM, of the Medication Nurse Cart Hall [NAME] 2 Tower with LVN T revealed she was unaware when the blister pack seals were broken, and she was not aware of who might have damaged the blisters. She stated the risk of a damaged blister would be drug diversion, residents not getting the proper medication and allergic reaction. She stated the nurses and medication aides were responsible for checking the medication blister packs for broken seals during the count of narcotics during the change of the shift. She stated the count was done at shift change and the count was correct. She stated she did not see the broken blisters during the count. She stated when a broken seal was observed, two nurses should discard the medication. Interview on 01/22/26 at 12:55 PM, the DON stated if a blister pack medication seal was broken the pill should be discarded. The DON stated it would not be acceptable to keep a pill in a blister pack that was opened. The DON stated the risk would be losing the medication because the seal was broken, infection control. The DON stated the nurses were responsible for checking the refrigerator and medication carts for expired medication and removed it. She stated nurses were responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated the ADON, and the DON were supposed to check the cart randomly. The DON stated they did in-services for the MAs and nurses on medication storage including no expired medications in the refrigerator, and the locked boxes for the controlled substance medication in the refrigerator were supposed to be anchored to the refrigerator for safety and no one would walk away with the box. Record review of the facility's policy Medication Access and Storage/Drug Destruction, revised July 2007 reflected the following: . Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closure are immediately removed from stock, disposed of according to procedures for medication destruction and reordered from the pharmacy, if a current order exist.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure that each resident received food that is palatable, attractive, and at a safe and appetizing temperature for 1 of 1 lunch meal tested for nutritive value, flavor, and appearance: The facility failed to provide food that was palatable and served at an appetizing temperature to residents, during lunch on 1/21/2026. This failure could affect the residents who ate food from the facility kitchen by placing them at risk of poor food intake and/or dissatisfaction of the meals served. Findings included: In an interview on 1/20/26 at 10:25 AM, Resident #24 stated that food was served cold sometimes. She stated that she still eats the food but cold food was not palatable. In an interview on 1/20/26 at 11:47 AM, Resident #58 stated that food was not tasting good. Food was cold at times. In an interview on 1/20/26 at 11:58 AM Resident #156 stated the food was cold and did not taste good. In an interview on 1/20/26 at 12:13 PM, Resident #39 stated the food was not always hot. In an observation on 1/21/26 at 11:35 AM of the [NAME] A taking food temperatures at the steam table before serving food revealed the temperature of lunch menu entree Penne [NAME] pasta was 145-degree Fahrenheit. In an Observation and Interview on 1/21/26 at 1:33 PM, a lunch test tray was sampled by [NAME] D and four surveyors. The sample tray consisted of 1 piece of garlic roasted chicken, penne alfredo pasta, 3/4 bowl of parsley carrots, 1 bread roll and 1 piece of banana foster cake. [NAME] D stated that pasta could be warmer, for it to taste better. The carrots and Garlic chicken were lukewarm to taste. [NAME] D measured the temperature of the pasta and it was 98-degree Fahrenheit. In a confidential group interview conducted on 1/21/26 at 2:00 PM, seven residents attending the group interview stated that the food was served cold. In an interview on 1/21/2026 at 1:48 PM with the Facility Dietitian, she stated that she was aware that residents in the facility had been complaining of cold food. She stated that the facility had obtained new plate warmer equipment last week. She stated food temperature was checked before service each meal. She stated that she had checked the pallet warmers that remained warm as well as steam tables were temping at appropriate temperature. She stated that the risk to residents for serving cold food was decreased palatability and possible poor food intake. She stated that all residents who complained of cold food were reviewed for weight loss. No residents met criteria requiring follow up for weight loss. In an interview on 1/21/2026 at 1:53 PM with the Administrator stated that he was aware of residents complaining of cold food. He stated that he put interventions in place such as changing the dietary manager in October of 2025 to supervise the efficiency of the kitchen service and buying new plate warmers for the kitchen last week to keep the food warm. He stated the new dietary manager was on leave for personal reasons and [NAME] D was the acting dietary manager. He also stated that he had hired new staff for the kitchen. He stated that risk of serving cold food was decreased food palatability. In an interview on 1/21/26 at 2:35 PM with [NAME] D revealed the kitchen received a new plate warmer equipment last week, however they equipment was not working well, it did not push the plates down enough when stacked up, as a result the plates remained stack up and did not heat up enough. She stated she had asked the maintenance tech to take out some springs at the bottom; however, the plates continue to stack up and do not go all the way down to keep the plates warm. She stated she had informed the maintenance personnel about the same, but no one had come to fix it. She added that food temperatures were taken before meal service. She stated the risk of serving cold food was food was not palatable and the residents would not eat as much. In an observation and interview on 1/21/26 at 2:49 PM with Facility Dietitian and Dietary Aide F, the new plate warmer unit did not stack up the plates all the way down to the bottom near the heating coil. Dietary Aide F stated that plates remain stacked up and do not collapse down near the base of the equipment to remain warm. The Facility Dietitian stated that if the plate stacked up, it would result in plates not being warmed enough for meal service. In an interview on 01/21/2026 at 3:08 PM with Maintenance Tech stated that the New Plate warming equipment was bought to the facility on 1/16/26. He stated that he came to the kitchen on 1/16/26 to remove a few (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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 for the facility's only kitchen in that: 1. The facility failed to ensure food item in the facility walk-in refrigerator were labeled and dated on 1/20/26. 2. The facility failed to ensure food items in the facility walk-in refrigerator were stored in sanitary condition on 1/20/26. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination. Findings included: Observation of the facility walk-in refrigerator on 1/20/2026 at 9:33 AM revealed 3 slices of turkey lunch meat were wrapped in plastic bag and did not have a use-by date and were not labeled. Observation of the facility walk-in refrigerator on 1/20/2026 at 9:35 AM revealed a cardboard box having about 10-12 raw sweet potatoes were moldy and white fungus growing on them. It also revealed 2 cabbage heads with rotten leaves with black discoloration on them lying in a cardboard box. In an interview on 1/20/2026 at 9:40 AM with [NAME] D, she stated that she was the morning cook and acting food service manager since the facility's Dietary Manager was out for extended leave. She stated that she would throw out the turkey meat and spoiled sweet potatoes and cabbage immediately after the interview. In an interview on 01/21/2026 at 1:48 PM with facility Dietitian revealed her expectation was all the food items should be labeled and dated. She stated that once the package is opened, they should be adding use-by date on the package and label the food contents. She stated that her expectation was all fresh produce should be checked for freshness and if the produce was moldy or spoiled, should be discarded immediately. She stated that she conducted sanitation audits once a month for the facility. Sanitation audits included ensuring foods were labeled/dated, food temperatures were adequately taken and recorded, ensuring all the equipment was in working condition, and ensuring food temperatures for freezers and refrigerators. She stated that the risk of not labeling and dating food items or storing spoiled produce was possible infection control concerns and food borne illness in residents. She revealed that the facility did not have a specific policy for Food storage and utilized either Texas Food Establishment Rules from the Texas Administrative Code or Food and Drug Administration (FDA) food code as guidelines for food storage and food safety. In a follow-up interview on 1/21/2026 at 2:35 PM with [NAME] D revealed everyone in the kitchen was responsible for dating and labeling food items in the kitchen. She stated that she was not aware who left the turkey slices in the refrigerator but should label it and put an use-by date on it. She stated that the fresh produce should be checked daily and the sweet potatoes and cabbage, that were spoiled, were discarded promptly on 1/20/26. She stated that fresh produce should be stored in sanitary condition in the walk-in refrigerator to ensure they do not spoil. She added that the risk of not dating or labeling food items as well as not storing produce appropriately can lead to food borne illness in residents. In an interview on 1/21/26 at 2:44 PM with Dietary Aide E revealed everyone working in the kitchen was responsible for dating, labeling food items. She stated that fresh produce should be stored appropriately to minimize their spoilage. She stated that all spoiled produce should be thrown away immediately and not used for cooking. She stated that risk of not dating or labeling food items as well as not storing produce appropriately can lead to residents getting sick. Review of the Food and Drug Administration (FDA) Food Code, dated 2022, reflected, .3-305 Preventing contamination from the premise 3-305.11 Food Storage (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination.		

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NAME OF PROVIDER OR SUPPLIER Golden Acres Living and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 Centerville Rd Dallas, TX 75228	
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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 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 3 of 6 Residents (Resident #157, Resident #13 and Resident #127) observed for infection control. 1.The facility failed to ensure CNA M and CNA L utilized Enhanced Barrier Precautions and performed hand hygiene during a mechanical lift transfer for Resident #157 and performed hand hygiene prior to leaving Resident #157's room on 01/20/26. 2.The facility failed to ensure CNA L performed hand hygiene during incontinence care for Resident # 13 and performed hand hygiene prior to leaving Resident #13's room on 01/20/26. 3. The facility failed to ensure Treatment Nurse P utilized Enhanced Barrier Precautions while performing wound care on Resident #127 on 01/21/26. These failures could place the residents at risk of cross-contamination and development of infection.Findings included: 1. Record Review of Resident #157's Face Sheet dated 01/22/26 reflected a [AGE] year-old female with an admission date of 11/12/24. Her diagnoses included Extended Spectrum Beta Lactamase (ESBL) (Type of enzyme produced by certain bacteria that makes them resistant to many common antibiotics, making infections harder to treat, often affecting the urinary tract, bloodstream and lungs). Record review of Resident #157's care plan with a revision date did not address the reason for Enhanced Barrier Precautions. In an observation on 01/20/26 at 10:40 a.m. a sign was observed posted on Resident #157's door, which indicated she was in enhanced barrier precautions. Upon entering the room CNA M stated she had just finished changing the resident and was going to get the mechanical lift and assistance to the get the resident up. CNA M left the room and within a few minutes returned with the mechanical lift and CNA L. Both CNAs put on gloves without performing hand hygiene and no gown. The CNAs proceeded to the hook the lift to the sling which had already been placed under the resident and transfer her to her wheelchair. CNA L guided the resident back into the wheelchair while CNA M lowered the mechanical lift. CNA L then removed her gloves and left the room with the lift without performing hand hygiene. CNA M finished adjusting the resident and then removed her gloves and left the room without performing hand hygiene. In an interview with LVN O on 01/20/26 at 11:00 a.m. she stated Resident #157 was in enhanced barrier precautions due to colonized ESBL in her urine. She stated the staff should be wearing PPE to perform high contact care, which included transfers. She stated she had been in enhanced barrier precautions for several months. In an interview on 01/20/26 at 11:15 a.m. with CNA M stated she did not notice the sign on the Resident #157's door and stated she worked yesterday and stated there was no sign on her door. She stated she should have noticed the sign and followed the protocols due to the risk of infection. She stated she had been in-serviced on enhanced barrier precautions and knew she was supposed to wear a gown during care of the resident, including transfers. In an interview on 01/20/26 at 1:15 p.m. with CNA L she stated she did not notice the sign on Resident #157's door and stated she was just helping with the transfer. She stated she guessed she should have worn the gown. She stated she had trained on enhanced barrier precautions and knew they were supposed to wear the gown and gloves when they provided incontinence care. She stated she was also supposed to perform hand hygiene when entering the room and before leaving and had failed to do that. 2. Record review of Resident #13's Face Sheet dated 01/22/2026, reflected an [AGE] year-old female with an admission date of 01/08/26. Her diagnoses included chronic obstructive pulmonary disease with exacerbation (progressive lung condition causing airflow blockage and breathing difficulties) In an observation on 01/20/2026 at 12:45 p.m. CNA L entered Resident #13's room to provide incontinence care. CNA L put on gloves without performing hand hygiene. CNA L opened the resident's brief and had her roll on her left side revealing she had a large loose bowel movement. CNA L wiped from front to back and changed and wiped multiple times but did not perform (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hand hygiene between glove changes. CNA L assisted the resident onto her other side to finish cleaning the resident, removed the soiled brief and under pad and the removed her gloves and put on clean gloves without performing hand hygiene. CNA L then applied barrier cream to the residents' buttocks and placed a clean brief under the resident and fastened the brief. CNA L gathered the trash and dirty linens, removed her gloves and left the room without performing hand hygiene. In an interview on 01/20/2026 at 12:55 p.m. with CNA L she stated she was supposed to perform hand hygiene before and after care and after gloves changes and stated she realized she had forgotten that. She stated the risk of not performing hand hygiene was the spread of infection to other residents. 3. Record review of Resident #127's Face Sheet dated 01/22/2026, reflected a [AGE] year-old female with an admission date of 01/18/26. Her diagnoses included diabetes and transmetatarsal amputation (removal of the fore foot just behind the toe). Record review of Resident #127's care plan with a revision date of 10/10/2025 reflected, Has wound.right foot.Interventions.Use Enhanced Barrier Precautions. An observation on 01/22/2026 at 11:35 a.m. revealed Treatment Nurse P outside of Resident #127's room preparing her wound care supplies. An EBP sign was posted on the door. Treatment Nurse P entered the room to assess the resident for pain and Resident #127 gave the okay for wound care to proceed. Treatment Nurse P returned to the medication cart, cleaned her bedside table and placed wax paper down. Treatment Nurse P then entered Resident #127's room, washed her hands and put on gloves, but no gown. She removed the old dressing from Resident #127's right foot and discarded it into a biohazard bag, removed her gloves and performed hand hygiene. Treatment Nurse P then cleansed the wound with saline gauze, removed her gloves, performed hand hygiene and put on clean gloves and placed the Dakin's (topical antiseptic used for disinfecting wounds) soaked gauze over the incision and covered with a dry dressing. Treatment Nurse P gathered the trash, removed her gloves and performed hand hygiene and left the room. In an interview on 01/21/2026 at 11:45 a.m. Treatment Nurse P stated any resident who had a wound required EBP and she stated, Oh my goodness, I did not wear a gown. She stated she had gowns on her cart and there were gowns in the resident's room. She stated she just simply forgot. She stated the reason for EBP was to prevent the spread of drug-resistant organisms from patient to patient. In an interview with the DON on 01/22/26 at 11:35 a.m. she stated staff were to change their gloves and perform hand hygiene before going form dirty to clean, before entering a resident's room and before leaving a resident's room. She stated all residents who were in Enhanced Barrier Precautions had signs posted on their doors and the staff was expected to follow those protocols. She stated they train and do in-services constantly on infection control. She stated that failing to follow those protocol places residents at a higher risk of infections. She stated they do monthly training on the use of PPE, how to appropriately don and doff, as well as annual skills checks. She stated all the staff knew the expectations. Record review of the facility's policy titled, Infection Prevention and Control, revised on May 2025, reflected, The facility will provide necessary Enhanced Barrier Precautions for resident care as needed.Facility management will post EBP signs and necessary PPE at the entrance of any room that contains a resident who had care appropriate for EBP. Facility staff will use necessary PPE to perform any care requiring the physical touch of a resident including but not limited to gowns and gloves. Record review of the facility policy titled, Hand Washing, revised May 2007, reflected, It is the policy of this facility to cleanse hands to prevent transmission of possible infectious material and to provide clean, health environment for residents and staff.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, interviews, and record review the facility failed to ensure that a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 1 (Resident #162) of 2 residents reviewed for catheter care. The facility failed to ensure Resident #162's urine drainage catheter bag was kept below the level of the bladder when the resident was up in his wheelchair. This failure could place residents at risk for urinary tract infections. Findings included: Record review of Resident #162's Quarterly MDS assessment, dated 01/01/26, reflected an admission date of 09/25/22. Resident #162 had a BIMS score of 09, meaning his cognition was moderately impaired. He coded section H bowel and bladder: indwelling foley catheter. Resident #162's active diagnoses included obstructive uropathy (condition where urine flows backward from the bladder into the ureters and sometimes the kidneys), hypertension (elevated blood pressure, diabetes mellitus (elevated blood sugar), Cerebrovascular accident (happens when blood flow to a part of the brain is blocked or a blood vessel ruptures, causing brain cells to die from lack of oxygen, leading to sudden disability or death) and None Alzheimer's dementia (progressive brain disorders). Record review of Resident #162's care plan, dated 12/16/25, reflected . [Resident#162] has indwelling catheter . Goal: will show no sign/symptoms of urinary infection . Interventions included .Position catheter bag and tubing below the level of the bladder and away from entrance room door . Observation on 01/22/26 at 11:08 AM revealed Resident#162 was up in wheelchair in his room, watching TV. Resident#162's foley catheter tubing was coming out of his pants going to the right side of his body at the level of his waist and looping to the back to the drainage bag inside a cloth holding bag hanging at the back of the Resident wheelchair. Urine was observed backing up in the tubing back toward the resident's bladder. In an interview and observation on 01/22/26 at 11:10 AM, LVN S looked at Resident#162 and stated it looks like the tubing was not strapped to the resident's thigh, and the urinary drainage bag was to be always kept below the resident's bladder. LVN S stated she would get a strap for the resident tubing, and make sure the drainage was hanging beneath the wheelchair seat to keep it below the Resident#162 bladder. She stated the tubing should be strapped to the resident tight to prevent them from pulling, and that by failing to keep the bag under the bladder level it would put the resident at risk for urinary tract infections. In an interview with the DON on 01/22/26 at 12:55 PM she stated the catheter was to be maintained below the level of the bladder. She stated having the drainage bag on holding bag behind the resident wheelchair was not maintaining it below the bladder. She stated by not keeping it below the bladder urine could back up into the bladder and increase the risk of urinary tract infections. She stated she would do skills check on nursing staff and the ADON would do random checks to monitor staff. Record review of the facility's policy titled, Incontinent care and Foley Care, revealed no documentation of ensuring the urinary collection bag was below the bladder. Review of the CDC, Guidelines for Preventions of Catheter- Associated Urinary Tract Infections, dated March 25, 2024, .III. B. 2 Keep the collecting bag below the level of the bladder at all times		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure all drugs and biologicals were stored in locked compartments under proper temperature controls for 2 Medication room (Medication room for [NAME] Hall, and the medication room for Hall [NAME] 1 Tower) of 4 medications rooms. The facility failed to ensure controlled substance medication safety box was anchored inside the refrigerated, and not removable. These failures could place residents at risk of not having the medication available due to possible drug diversion and at risk of not receiving the intended therapeutic benefit of the medication. Findings included: In an observation and interview on 01/20/26 at 10:29 AM the refrigerator in the medication room for Hall [NAME] 1 Tower had a locked clear see through plastic box with two boxes of Lorazepam oral concentration 2 mg/ml (controlled medication used for anxiety). The Plastic box was not anchored to the refrigerator. LVN U stated she did not know how long the controlled substance box had been in the refrigerator not anchored. She stated anyone could take the controlled substance box from the refrigerator. LVN U stated no anchored controlled substance box could lead to drug been lost or stolen, drug diversion, and residents not having their medication ready for use whenever they needed it. Interview on 01/22/26 at 12:55 PM, the DON stated the nurses were responsible for checking the refrigerator and medication carts for expired medication and removed it. The DON stated the ADON, and the DON were supposed to check the cart randomly. The DON stated they did in-services for the MAs and nurses on medication storage including no expired medications in the refrigerator, and the locked boxes for the controlled substance medication in the refrigerator were supposed to be anchored to the refrigerator for safety and no one would walk away with the box. Record review of the facility's policy Medication Access and Storage/Drug Destruction, revised July 2007 reflected the following: . Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closure are immediately removed from stock, disposed of according to procedures for medication destruction and reordered from the pharmacy, if a current order exist.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident bedside was adequately equipped to allow all residents to call for staff assistance through a communication system that would relay the call directly to a staff member or a centralized staff work area for 1 of 7 residents (Resident# 67) reviewed for residents' call system. The facility failed on 01/20/2026 to ensure the call light system was working and available to Resident #67 These failures could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they needed support for daily living. Record review of Resident #67's MDS assessment dated [DATE] reflected he was a [AGE] year old male with an admission date of 12/05/2024. His diagnoses included Alzheimer's disease with early onset (a brain disorder that destroys memory, thinking, and reasoning skills), spinal stenosis (narrowing of the spinal canal which causes pain), thrombocytopenia (low number of platelets in blood which can cause bleeding). Record review of Resident #67's care plan dated 12/17/2024 revealed he had alteration in musculoskeletal status related to fracture of the L olecranon. goal: will remain free of injuries. interventions: Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. ADL self-care performance deficit related to limited mobility, Dementia dated 12/10/2024, Goal: will maintain current level of function in. toilet use and personal hygiene, Interventions: . Toilet use. requires staff assistance x 1-2 to use toilet. Observation and interview on 01/20/2026 at 10:31 AM revealed Resident #67 was sitting in his bed, his call light device cord was tied around a monitoring device on the wall. Resident #67 stated his call light was not working for a few days, and he had no means to call for assistance other than yell. An interview on 01/26/2026 at 11:41 AM with CNA G revealed she was not aware that Resident #67's call light device was not working. She stated all the employees were responsible for making sure resident call lights were always working and within reach of the resident. She said the maintenance director was ultimately responsible for repairing and maintaining working call lights for all residents. She stated residents were at risk for falls, injury, delay in care if they did not have a working call light device. She stated they had an online system to report any maintenance issue to the maintenance director. An interview and observation on 01/26/2026 at 11:52 AM with LPN J revealed he was the charge nurse, he did not know Resident #67's call light device was not working. Observation revealed LPN J checking Resident #67's call light which was wrapped around a monitoring device on the wall, and he stated it was not working. He stated it was the responsibility of all the employees to ensure the call light was within reach of the resident and always working, notifying the maintenance if the device was not working. He stated the maintenance director was responsible for repairing and maintaining all the call light devices. He stated residents were at risk for falls, injury, delay in care if they did not have a working call light device. He stated he would give the resident a bell to call for help, if he knew the call light was not working. An interview on 01/20/2026 at 12:04 PM with CNA H revealed she was not aware that Resident #67's call light device was not working. She stated all the employees were responsible for making sure resident call lights were always working and within reach of the resident. She said the maintenance director was ultimately responsible for repairing and maintaining working call lights for all residents. She stated residents were at risk for falls, injury, delay in care if they did not have a working call light device. She stated they had an online system to report any maintenance issue to the maintenance director. An interview 01/20/2026 at 2:43 PM with LVN K revealed she was the charge nurse, she did not know Resident #67's call light device was not working. She stated it was the responsibility of all the employees to ensure the call light was within reach of the resident and always working, notifying the maintenance if the device was not working. She stated the maintenance director was responsible for repairing and maintaining all the call light devices. She stated residents were at risk for falls, injury, delay in care if they did not have a working call light device. An interview on 01/20/2026 at 3:11 PM with CNA I (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed he was not aware that Resident #67's call light device was not working. He stated it was the responsibility of all the employees to ensure the call light was within reach of the resident and always working, notifying the maintenance if the device was not working. He stated the maintenance director was responsible for repairing and maintaining all the call light devices. He stated residents were at risk for falls, injury, delay in care if they did not have a working call light device. An interview with the Maintenance director on 01/21/2026 at 02:21 PM revealed he came to know during a routine call light device check last Thursday that Resident #67's call light device was not working, and he had given a bell to the nurse on the same day to give it to Resident #67 to temporarily use until the call light device was repaired. He stated he had contacted the alarm company the same day and placed a work order, they came and looked at it on Friday and awaiting a part to complete the repairs. On 01/21/2026 at 01:40 PM, it was observed that Resident #67 had a bell next to his bed to call for assistance. An interview on 01/22/2026 at 12:10 PM with the DON revealed she expected all employees to make sure the residents had a working call light device at all times, report immediately to the charge nurse, maintenance director if a call light device was not working, and provide a temporary bell to the resident until the call light device was repaired. She stated residents were at risk for falls, injury and delay in care if they did not have a working call light device within reach. An interview with the Administrator on 01/22/2026 at 12:22 PM revealed he expected the residents to always have a working call light device, and it was the responsibility of all the employees to report to the maintenance director if a call light was not working. He stated residents were at risk for falls, injury and delay in care if they did not have a working call light device. He stated the maintenance director was responsible for repair and maintenance of call light devices. Record review of facility policy titled policy/procedure-nursing clinical, section: routine procedure, Subject: call light/bell, policy number: NCRP19 dated 05/2020 reflected it is the policy of this facility to provide the resident a means of communication with nursing staff. Procedures: . 5. Place the call device within resident's reach before leaving the room. If the call light/bell is defective, immediately report this information to the unit supervisor.		